OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

29 May 2024

Agenda item	Organisational Risk Report
Board Lead	Joanna James, Trust Board Business Manager
Type name of Author	Joanna James, Trust Board Business Manager
Attachments	Appendix 1 - Corporate Risk Register (CRR) Report Appendix 2 - CRR Heatmap Appendix 3 - Board Assurance Framework Report (BAF)
Purpose	Assurance
Previously considered	EMC 07.05.2024 Audit Committee 09.05.2024

Executive Summary

This report provides an overview of current risk within the organisation, considering both strategic and operational risks as well as the Trust's risk appetite for each of the strategic objectives. An update is also provided on work within the Trust to improve overall management of risk.

At the time of writing the report, the Trust was carrying a high level of risk related to finance, people, quality and performance and estates and facilities, above the Board's appetite for such risk.

Since the previous report, the Executive Management Committee (EMC) agreed the following:

- CRR 431 (Homecare service for new patients – de-escalated
- CRR 82 (Poor flow out of ED) – de-escalated.
- CRR 56 (Concrete panels, Wycombe Tower) – closed.
- CRR 48 (Ageing endoscopy equipment) – escalated.

All principal risks within the BAF have been reviewed or are under review, the summary page provides more information. The content of the BAF is being migrated to a new platform and reporting in a revised format will be presented from July 2024.

Decision	The Board is requested to note the contents of the report and use this information to support risk-based discussions and decision making.

Relevant Strategic Priority

Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☒

Relevant objective

☐ Improve waiting times in ED ☐ Improve elective waiting times ☐ Improve safety through clinical accreditation	☐ Give children living in most deprived communities the best start in life ☐ Outpatient blood pressure checks	☐ Zero tolerance to bullying

Implications / Impact

Patient Safety	There are a significant number of operational mapped to the Trust ambition to 'meet/exceed quality and performance standards'.
Risk: link to Board Assurance Framework (BAF)/Risk Register	This paper attempts to highlight and map risks from the Corporate Risk Register (CRR) aligned to the Trust's strategic objectives and principal risks.

Financial	Two risks from the CRR are mapped against the objective to 'deliver a financially sustainable plan'.
Compliance CQC Standards Good Governance	An effective, comprehensive process is required to be in place to identify, understand, monitor and address current and future risks to the organisation
Partnership: consultation / communication	No CRR risks have been mapped against the objective to 'work with partners and engage people'.
Equality	Specific attention to issues related to equality are considered in relation to the Trust ambition to 'reduce health inequalities' and 'deliver people priorities'.
Quality Impact Assessment [QIA] completion required?	n/a

1 Introduction

The purpose of this report is to provide a summary of current risk within the organisation considering the detail of both those risks within the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF).

2 Risks mapped to Strategic Objectives

The table below lists the nine Strategic Objectives of the Trust as documented in the BHT Strategy 2025. For each objective, the risk appetite of the Board is noted, the number of high scoring operational risks within the CRR and the risk rating of the relevant Principal and CRR risks (maximum, minimum and average for the latter). This is intended to provide a more global overview of the risk portfolio in each area.

No.	Strategic Objective	Risk Appetite (max. 5)	Principal Risk RR*	No. of Corporate Risks mapped to Objective	Maximum RRR** (Corporate Risks)	Minimum RRR (Corporate Risks)	Average RRR - Mean (Corporate Risks)
1	Consistently meet or exceed quality and performance standards	2.5	12	5	25	12	18 Increased
2	Deliver a financially sustainable plan	2.5	12	2	20	12	16 No change
3	Work with partners and engage people	4	9	0	-	-	- No change
4	Ensure children get the best start in life	2.5	12	0	-	-	- No change
5 6	Use population health analytics to reduce health inequalities and improve outcomes Improve the wellbeing of communities	4	9	0	-	-	- No change
7	Deliver People priorities	2	12	3	15	20	16 No change
8	For buildings and facilities to be great places to work	3	16	6	20	20	20 No change
9	Maximise opportunities for improving, sharing good practice and learning	4	9	0	-	-	- No change

**RR – Risk Rating; **RRR – Residual Risk Rating*
No change in any Principal Risk Ratings.

The amber and red colouring is intended to highlight those areas of most significant risk.

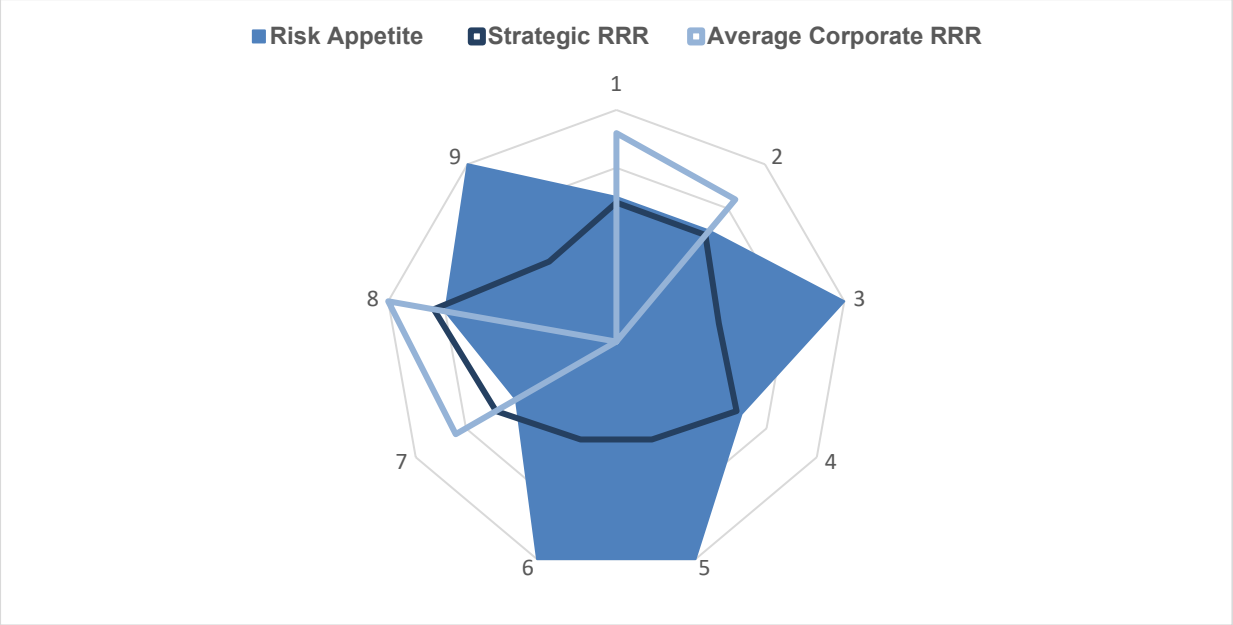
Since the previous report, the Executive Management Committee (EMC) agreed the following:

- CRR 431 (Homecare service for new patients – de-escalated
- CRR 82 (Poor flow out of ED) – de-escalated.
- CRR 56 (Concrete panels, Wycombe Tower) – closed.
- CRR 48 (Ageing endoscopy equipment) – escalated.

These changes have not changed the data in the table above.

3 Risk Appetite

The diagram below displays the residual ratings for each strategic risk and the average risk ratings of corporate risks against the Trust risk appetite, demonstrating where these are aligned/misaligned.



The diagram indicates the Trust is carrying higher risk than set out in the risk appetite in relation to quality and performance, finance, people and buildings and facilities. The Trust is open to more risk than it is currently carrying in relation to working with partners, healthy communities and innovation and learning.

4 Risk Management KPI Dashboard

The table overleaf provides high level information on how risk is being managed each month. For more detail on each specific risk, the CRR and BAF papers are included as an appendix.

Month	% Strategic Risks reviewed	% Operational Risks reviewed	% Actions Overdue Operational risks	Balance of assurance Internal v External	Number of new risks	Number of removed risks Closed/de-escalated from CRR	% risks with increased scores Strategic	% risks with reduced scores Strategic	% risks with static scores Strategic	% risks with increased scores Operational	% risks with reduced scores Operational	% risks with static scores Operational
Jan 2024	75%	50%	70%	Med	0	0	0%	0%	100%	0%	0%	100%
Feb 2024	88%	50%	70%	Med	1	0	0%	0%	100%	0%	0%	100%
Mar 2024	88%	69%	62%	Med	0	1	0%	0%	100%	0%	0%	100%
Apr 2024	100%	53%	75%	Med	1	3	0%	0%	100%	0%	0%	100%

The next report will also include the dwell time of risks on the CRR.

5 Action required from the Board/Committee

The Board is requested to note the contents of the report and use this information to support risk-based discussions and decision making.

APPENDICES

Appendix 1: Corporate Risk Register (CRR) Update Report
Appendix 2: CRR Heatmap
Appendix 3: Board Assurance Framework (BAF) Report

Appendix 1: Corporate Risk Register Report

1. Purpose

This report provides an update on risks on the Corporate Risk Register (CRR).

2. Background

The CRR is reviewed monthly with the risk owner or relevant representative to consider the score, mitigations, gaps in control, actions update and progress update. Additionally, monthly reviews are completed with executive directors for risks within their portfolios.

The process for the CRR is that all new and current risks scored at 15 or above on the Care Group and Corporate Service risk registers are reviewed and reported on at the Risk and Compliance Monitoring Group (RCMG) every month. The RCMG review guides the Executive Management Committee (EMC) in moderating risks for escalation or de-escalation onto and from the CRR.

3. Updates

There are currently 15 risks on the CRR. Quality assurance work (including updates) is carried out monthly through RCMG as per the policy. The table overleaf details updates to individual risks.

4. Risk & Compliance Monitoring Group (RCMG)

Following recent RCMG meetings, EMC considered the following at the meeting on 7 May 2024:

a) Risks for escalation to the CRR

- Risk 48 – Ageing/failing equipment within endoscopy decontamination (SMH) – **approved**; risk owners to consider whether capacity risks in endoscopy should be combined as one risk.
- Risk 398 – Reduced orthogeriatrician input – **not approved**; further work to be undertaken reviewing specialty medical input more widely.

b) Risks for de-escalation/removal from the CRR

- Risk 82 – Poor flow out of ED – **approved**; to be de-escalated from the CRR and remain on the Integrated Medicine Care Group risk register.
- Risk 56 – Risk of concrete panels falling (Wycombe Tower exterior) – **approved to close;** concrete panels removed from the exterior of the tower

To note risk 431 (financial impact and care inequality through reduced Homecare provision for new patients) was considered by EMC in April 2024 and approved for de-escalation from the CRR.

In view of the current nursing vacancy rate, EMC have also discussed risk 51 (nursing workforce). There is a plan to consider de-escalation of this risk for monitoring by the people directorate. Teams are working to ensure specific areas of high risk related to nursing workforce are accurately reflected within risk register.

Minutes of RCMG meetings are provided to EMC for information.

5. **Risk actions**
   Risk actions are monitored monthly during RCMG meetings. Risks where actions are not articulated continue to be reviewed as a part of the risk quality assurance work.

6. **Action required from the Committee**
   The Committee are required to:
   a) Note and take assurance from the updates to the CRR.
   b) Note those risks for escalation/de-escalation to the CRR and the decision made by EMC.

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
51	Workforce - nursing	A shortage of registered and unregistered nursing staff, which results in high reliance on temporary staffing (Bank and Agency) in some areas which could impact on the quality of patient care, the wellbeing of permanently employed colleagues and the Trust financial position.	15/04 2024 - Risk discussed at EMC not for de-escalation at this time. Risk to be reviewed outside of the meeting and further discussions to be had prior to de-escalation.	15	15	↔
119	There is a risk that patients are not being followed up appropriately due to being on the 'on hold' list	Review of data (captured in June 2022) demonstrates 116,575 “on-hold” records affecting a total of 108,458 patients. There is a potential for unmanaged clinical risk unless the status of these patients are understood and actioned appropriately.	29/04/2024 - discussed at CG gov meeting 25/04/24 - recommendation to be made at next IPR meeting that risk can be reduced. wording needs updating before then	20	12	↔↓
184	The ageing WH tower Block is showing signs of interior deterioration, which is challenging to maintain.	The ageing WH tower Block is showing signs of interior deterioration which is challenging to maintain in a condition suitable for modern healthcare provision.	08/02/2024 - Updated by SH & AP - Work has commenced to vacate the top 2 floors 6&7, this should be completed by end of April 24. Active strategy in the programme business case to remove all services from the tower over the next 4 years (subject to available funding). Small improvements have been made to level 1 and 5 to Endoscopy and Cardiac services to maintain the ability to provide clinical services.	25	20	↔↔
189	Risk of industrial action in relation to national pay award	Risk of industrial action in relation to national pay awards. Patient care may be impacted if the industrial action takes place.	05/04/2024 – Actions updated.	12	20	↑↔
190	The Ward 2a environment remains non-compliant with CQC Regulation 15 - premises and equipment	The premises (building fabric) and equipment (CD cupboard; medication mixing facilities) are non-compliant with CQC regulation 15 which stipulates that premises where care and treatment are delivered are clean, maintained and suitable for the intended purpose. This risk has been highlighted by the CQC (as an environment not fit for purpose) and documented in their reports following last two inspections.	15/04/2024 - Floor works complete. SDU to review risk and actions at next governance meeting 16/04/2024	20	20	↔↔
224	There is a risk that Trust Capital Resourcing is insufficient to support operational objectives for 2023-24.	For 2022/23, the Trust has a total capital requirement of £128.8m split between property services £104.4m, IT £18.2m and Medical Equipment £6.4m. BOB ICS has allocated a notional £20m capital envelope for BHT, which is only a sixth of the total requirement, leaving a funding shortfall of £108.8m. As in previous years, further funding streams may become available later in the year, but it would not be prudent to factor this in at this stage.	30/05/2023 – updated with handler to be changed to Deputy CFO when available on Datix	25	20	↔↔

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
225	There is a risk of disruption to Trust technology systems and services caused by cyberattacks.	There is a risk that the aged applications running on out of date Microsoft servers, network and telephony systems upon which the Trust relies are vulnerable to cyber-attack as they are no longer receive vendor security updates.	09/05/2024 – Reviewed; updated key controls and gaps in controls. Risk rating unchanged.	20	20	↔↔
234	There is a risk to the delivery of the Financial Plan due to insufficient financial envelop.	Trust is unable to define / live within its financial envelope impacting on its ability to resource / deliver clinical, operational and strategic priorities.	30/05/2023 – Updated with CFO; handlers changed for risk and action.	20	12	↔↔
410	Wycombe Hospital Site - Marlow & Main THs block	Wycombe site Marlow theatres - currently theatre 2 out of action and 2 theatres struggling to meet accreditation standards regularly Ventilation and infrastructure, old and needs full refurbishment. Including inadequate recovery space. GPAS/RCoA guidance and HTM0301 not met. Currently, theatre 1 and 3 are maintained to HTM standard. Theatre 2 is not able to be maintained to HTM standard. Break down and downtimes becoming a regular occurrence Wycombe Main: Theatre 3 upon revalidation is no longer compliance with HTM standards Theatre 1 and 2 just meeting HTM standards, however, the entire suite will need infrastructure and ventilation refurbishment. Not longer able to meet standards and breakdown are becoming a regular occurrence.	28/03/2024 - Facilitator Division of Surgery and Critical Care 28/03/2024 10:25:55 Conducted a sub million £ refurbishment programme for 2023/24 and risk will be re-assessed for all sites (cross site) going forwards in new fiscal year. Will be embarking on a further 12 months maintenance programme to ensure all sites operational and robust for future use. Update required from clinical team and estates team.	20	20	↔↔
415	New Wing Theatres Block (1-5)	New Wing Theatres block SMH (THs 1-5) currently at the end of life stage, and in need of full refurbishment in the next 12-24 months. Currently ventilation not meeting HTM standards in TH4 Anaes RM, and risk of electrical failure and ventilation failure in all theatres. Additionally heating coils and boilers at end of life and have frequent failures resulting in downtime and loss of service.	28/03/2024 - Conducted a sub million £ refurbishment programme for 2023/24 and risk will be re-assessed for all sites (cross site) going forwards in new fiscal year. Will be embarking on a further 12 months maintenance programme to ensure all sites operational and robust for future use. Update required from clinical team and estates team.	20	20	↔↔
320	Risks of Endoscopy Waiting Lists Leading to Delays in Procedures and Diagnosis.	Currently short of capacity in Endoscopy. This has been made worse by COVID. Delays in surveillance appointments, which means that there have been delays in removing polyps, which have now turned into cancer. Number of patients have been diagnosed with cancer, which may have been avoidable.	15/04/2024 - New attachment showing years activity, units are working at high levels of productivity. Limitations with equipment and infrastructure are the leading cause of delays. These factors are addressed in alternative risks.	25	25	↔↔

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
287	Maintenance of safe staffing levels	A shortage of registered and unregistered midwifery staff, which results in high reliance on temporary staffing (Bank and Agency) in some areas which could impact on the quality of patient care, the wellbeing of permanently employed colleagues and the Trust financial position.	01/05/2024 - 27 WTE NQMs committed to a start date during the autumn of 2024 which will significantly reduce vacancy. Funding for R&R specialist has not yet been provided by NHSE	15	15	↔
597	Lack of commissioned TVN service (community)	Under resourced team have approached the ICB for funding to support the service across winter months. The current service does not have the capacity to meet demand being asked particularly supporting referrals received from GP Practices and Nursing Homes. If patients in the community are not provided the necessary care and support this could lead to an increase in ED visits/Hospital admissions for wound infections/complex leg and pressure ulcers etc. 30 patients from nursing homes on the waiting list for assessments. Clinics have been put on hold for GP patients Current staffing situation of both senior TVNs leaving in March and April 24. Without suitable recruitment there is a significant risk to service provision. The team have noted a increase in staff stress and related sickness, and as a result the team are now only able to offer email advice to care homes and GP practices.	14/03/2024 - Risk Approved to be escalated to the CRR as per the 5/3/2024 EMC outcome.	25	20	↑↑
388	Misapplication of the Mental capacity act including unlawful deprivations of liberty.	There is a risk that people may be deprived of their liberty unlawfully which could lead to risk of liability to Trust including risk of breach of Human Rights. This could to a delay in pursuing appropriate legal avenues including application to the court of protection. This could lead to unlawful detention in hospital, increased length of stay and poor patient experience. Risk of making decisions on behalf of an adult without legal framework to do so. The safeguarding team do not have capacity to review all MCA assessments linked to Deprivation of Liberty Applications. BHT have become aware through an individual case that the Local Authority have delays in being able to review applications for Deprivation and therefore granting the appropriate application. If a patient is actively objecting the Supervisory Body (Local Authority) should assess with a Best Interest Assessment. There is a risk that colleagues will not recognise the application of the MCA for 16 & 17 year olds.	29/02/2024 - Risk reviewed by TS and CR to update actions and gaps in control. Risk score remains the same. Risk to be reviewed again in 2 weeks with DCN.	15	15	↔↔
48	Ageing/failing equipment endoscopy decontamination (SMH)	We have a aging plant. The electronic washer disinfectors are coming to an end of life cycle, requiring more frequent maintenance and breakdown causing disruption to the service. Breakdowns include drainage, pumps, washers etc.	15/04/2024 - Actions updated, Discussed in divisional risk review meeting with Helen Byrne and governance team.	20	20	↑↑

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
		Currently there are only 3 out of 4 chambers in a working condition; however the 3 working chambers are also coming to an end of the life cycle. The most recent breakdown led to a RIDDOR reportable incident (ID 2377). Frequent breakdowns lead to compromised washing facilities and reduced lists. Delays in engineer response and appropriate maintenance. The plant room is not fit for purpose as the heat exchange is insufficient to cool resulting in the need to open the door risking exposure to aerosolised contaminate. The extract system is also insufficient and does not meet HTM 01-03 for extract in case of chemical leak. The system is build on a single circuit resulting in no failsafe, and no business contingency. there is no available monitoring method to allow assessment of thermal disinfection efficacy or occurrence. any modifications would now fall into the latest htm standards resulting in a major refurbishment of the whole unit.	Risk to be escalated at RCMG for Corporate risk register risk raised to 20. New incidents to be linked			

Risk Heat Map – Corporate Risk Register – May 2024

Buckinghamshire Healthcare NHS Trust

Key: ↑ = risk score has increased; ↓ = risk score has decreased; ⇔ = no change.
The CRR changes on a monthly basis and the arrows indicate the change since the previous version.

Likelihood \ Consequence	1	2	3	4	5
5			388 – Application of MCA/DoLs ⇔ 287 – Midwifery Staffing ⇧	190 – Ward 2a environment non-compliant with CQC Regulation 15- premises and equipment ⇔ 410 – Wycombe Hospital Theatres ⇔ 415 – SMH Theatres ⇔ 597 – Lack of commissioned TVN service (community) ⇧ 189 – Industrial Action ⇔ 48 – Ageing/failing equipment endoscopy decontamination ⇧	320 – Risk of endoscopy waiting lists leading to delays in procedures and diagnosis. ⇔
4					224 – Risk that Trust Capital Resourcing is insufficient to support operational objectives for 2023/24. ⇔ 225 – Risk of disruption to Trust technology systems and services caused by cyber incidents ⇔ 184 – The ageing WH tower Block is showing signs of interior deterioration which is challenging to maintain.⇔
3				234 – There is a risk to the delivery of the 2023-24 Financial Plan due to unplanned pressures ⇔. 119 – There is a risk that patients are not being followed up appropriately due to being on the 'on hold' list ⇔	51 –Workforce – nursing ⇔
2					
1					

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
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NHS Trust

Board Assurance Framework

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1.0 Introduction & Summary of Changes

This report provides the Board with an opportunity to discuss the range of risks confronting the organisation, any gaps in controls/assurances and the level of risk that this creates to support strategic decision making.

Where updates have been provided by colleagues, this has been indicated in the 'last review' box for each risk. All risks have been reviewed since the previous report. A comprehensive review of risks 1(a), 1(b), 2 and 7(a) is currently underway recognising the imminent finalisation of the 2024/25 Operating Plan and the appointment of the Chief Estates and Facilities Officer.

Risks from the Board Assurance Framework are being migrated onto the new 4risk platform and reporting to the Board will be in a revised format from July 2024. During the Committee Effectiveness review of Audit Committee, the inclusion of the Integrated Care System (ICS) risk register was suggested. This will be appended to the next report to Audit Committee to consider how best to consider this going forwards.

2.0 Strategic Objectives

Each strategic objective is detailed on the following pages.

1. To consistently meet or exceed quality and performance standards.
2. To deliver a financially sustainable plan and improve our benchmarking in model hospital.
3. To work with our partners and engage people.
4. To ensure children get the best start in life.
5. To use population health analytics to reduce health in equalities and improve outcomes in major diseases.
6. To improve the wellbeing of communities.
7. To deliver our 5 people priorities.
8. For our buildings and facilities to be great places to work and contribute to the health and wellbeing of our staff.
9. To maximise opportunities for improving, sharing good practice and learning.

2.1 Strategic Objective 1 Principal Risk; Failure to provide care that consistently meets or exceeds performance and quality standards

Strategic Objective 1	**To consistently meet or exceed quality and performance standards**
Achieve by 2025…	**We will see people as early as possible when they need our services, to improve outcomes**
Strategic Priority	Provide outstanding, high value care ("Outstanding Care")
Principal Risk	1. Failure to provide care that consistently meets or exceeds performance and quality standards including safety, experience and outcome: a) Reducing long waits. b) Providing safe emergency care. c) Management of risk and clinical governance.

	d) Maternity & Neonatal care.				
Executive Lead	Chief Operating Officer (1a, 1b) Chief Nurse (1c, 1d)		**Oversight Committee**	Finance & Business Performance Committee* - last review March 2024 Quality & Clinical Governance Committee* - last review February 2024	
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**		
Impact 4 Likelihood 5 **Total Score 20**	Impact 3 Likelihood 4 **Total Score 12**	**Minimal-Cautious (2-3)**	CRR 119	Follow up 'on hold' waiting lists	
			CRR 58	Ageing/failing equipment within endoscopy decontamination	
			CRR 388	Application of MCA and DoLs	
Last Review	Chief Nurse 28 July 2023 Chief Operating Officer – **currently under review** Director of Midwifery 21 May 2024		CRR 320	Delays in endoscopy procedures and diagnoses	
			CRR 597	Lack of commissioned TVN community service	
Movement in Risk	None				

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
1a. Reducing long waits				
Limitations in capacity and growing capacity due to estate infrastructure Variation in the productivity of clinical service lines Inadequate oversight of harm caused by COVID-19 pandemic. Underutilisation of effective data and Business intelligence.	- Staff resilience. - Clinical, operational, financial and regulatory consequences - Unable to replace/restore faulty estate and equipment - Failure to maximise clinical resources to reduce waiting lists and meet regulatory standards - Harm caused by delayed treatment - Political mistrust/lack of confidence in management. - Poor patient experience.	- Optimisation of available capital investment; prioritisation of business cases for maintenance. - PFI investment. - Planned care transformation programme including focus on elective productivity Structured harm review process across elective care and cancer - GIRFT reviews. - Productivity metrics. - Flag function on Datix. - Prioritisation of waiting lists by clinical risk and long wait status. - ICS wide working on cancer and elective performance - External audits/reviews. - Suite of dashboards to monitor performance.	- Outputs from relevant meetings (level 1) - Monthly reporting on performance metrics through IPR (1). - Records of deep dives/escalation calls (1). - Outputs of monthly Capital Management Group (1). - Use of CAFM system (2). - Monthly reporting to Transformation Board (1). - GIRFT reporting/outputs of Board (3). - Theatre dashboard (1). - Audit of appropriateness of risk allocation (1). - Triangulation with Datix reporting (1). - CQC insights report (3). - Dr Foster report (3). - IQVIA report (3). - Mortality report/learning from deaths (1). - Litigation report (1). - National inpatient survey results (3). - Safeguarding reports (1). - External reviews (3).	**Action**: Endoscopy Improvement Programme – oversight through the IPR
1b. Providing safe emergency care				

Inability to control demand for services or primary/social care capacity Inability to reform the urgent care pathway Inadequate infection, prevention and control due to estates infrastructure	- Overcrowding and extended length of stay within ED. - Ambulance handover delays - Staff resilience. - Clinical, operational, financial and regulatory consequences - Challenging/costly to clean clinical areas effectively. - Potential for hospital acquired infections. - Harm caused by delayed treatment - Political mistrust/lack of confidence in management. - Poor patient experience.	- Incident response structure; Gold/Silver/Bronze. - Site management processes including regular ED huddles - Place-based delivery board. - Place-based escalation protocol, admission avoidance and discharge action plans. - Long stay deep dives - Discharge escalation calls with partners. - Place UEC Board. - Paeds ED development - Cleaning audits, completed in line with National Standards of Healthcare Cleanliness - Nominated cleaning lead and processes for audit and reporting in line with the requirements of CQC Regulation 15 and Health and Social Care Act Code of Practice - Daily IPC huddles. - Infection control audits (monthly). - Adhoc outbreak meetings. - Quarterly IPC committee. - Optimisation of available capital investment; prioritisation of business cases for maintenance work. - PFI investment. - Divisional performance reviews. - External audits and reviews. - Dashboards for performance monitoring.	- Outputs from relevant meetings (level 1) - Outputs from ED huddles (1). - Monthly reporting on performance metrics through IPR (1). - Records of deep dives/escalation calls (1). - Cleaning audit reports (1). - Terms of reference and outputs of IPC Committee (2). - Outputs of monthly Capital Management Group (1). - Use of CAFM system (2). - Monthly reporting to Transformation Board (1). - GIRFT reporting/outputs of Board (3). - CQC insights report (3). - Dr Foster report (3). - IQVIA report (3). - Mortality report/learning from deaths (1). - Litigation report (1). - National inpatient survey results (3). - Safeguarding reports (1). - External reviews (3). - Safe (safest) staffing; daily huddles and regular reporting to Board/Board Committee (1)	**Action:** UEC Improvement Plan (COO) – oversight by F&BPC through deep dive programme **Action**: Winter Plan (COO) – oversight by F&BPC through deep dive programme **Action:** MOfD Improvement Plan (COO) – oversight by F&BPC through deep dive programme *NB – F&BPC Deep Dive Programme under ongoing consideration by the Committee*
1c. Management of risk and clinical governance				
Variation in clinical service lines Organisational governance not always being easy to navigate and enabling of change	- Inadequate ward-board assurance.	- Clinical accreditation programme. - Quality audits via Tendable.	- Data reported through Tendable app; reported to Q&PSG/Q&CGC (level 2).	
1d. Maternity and Neonatal Care				

Maternity and neonatal staffing levels Data quality Digital immaturity Antenatal pathway capacity Size of bed base within neonatal unit and transitional care Health inequalities Increasing complexity of service users	- Staff burnout creating further vacancy owing to attrition and unavailability - Potential for clinical harm - Clinical, operational, financial and regulatory consequences. - Political mistrust/lack of confidence in management. - Ability to plan sustainable services and manage demand and capacity. - Patient experience. - Inability to meet information governance standards	Development of a robust recruitment and retention plan to increase recruitment of experienced midwives and develop pipeline for future NQMs Six-monthly staffing oversight report to Board to highlight key limiting factors to successful recruitment and retention Compliance with BirthRate Plus recommendations for funded establishment and reporting of acuity >90% Development of a system wide quality and safety dashboard to provide improved oversight of metrics and drive clinical performance. Continued reporting via the perinatal quality surveillance model Increase in system based projects to reduce local resource burden owing to duplication Continued oversight from Board level Maternity and Neonatal Safety Champions Oversight of the services performance against all 10 of the Maternity Incentive Scheme's safety actions (as part of CNST) Assurance that progress is being made with Care Group business and performance plan Implementation of the LMNS Opel classification and escalation processes including attendance at daily safety huddles Implementation of electronic patient record by February 2025 Dedicated governance structure for maternity, gynaecology, and neonates with reporting to Chief Nurse via Director of Midwifery	- Quarterly maternity safety reports including full HSIB and SI reports for board oversight, scrutiny and transparency(1). - Quarterly maternity quality report including monthly perinatal quality surveillance report (PQSM) (1) - Compliance with HSIB investigation safety recommendations(3). -HSIB quarterly feedback (3) - External reviews(antenatal and newborn screening quality assurance, CQC)(3). - Annual Picker survey of women's experiences (3). - Maternity services performance board (3). - Outputs from QI projects (1). - Claims/litigation scorecard (1). - Annual maternal and perinatal MBRRACE reports (3). - Maternity Incentive Scheme (CNST) (1). - Ockenden compliance reports (1). - 'Saving babies lives bundle version 3' compliance(3). - Quarterly patient feedback survey via Maternity and Neonatal Voices Partnership (MNVP) (3). -15 steps reports via MNVP (3) - Annual MNVP report (3) - Six monthly maternity staffing reports (1). - Implementation of single delivery plan oversight by Board Completion of 'must do' actions from Maternity CQC inspection ASSURANCE LEVEL **MEDIUM**	**Actions:** Action plans and trackers to monitor compliance with : - Maternity Incentive Scheme (CNST) - Ockenden immediate and essential actions - Saving Babies Lives version 2 - MBRRACE - NHSR Early notification scheme - Perinatal mortality review tool - Picker survey - External reviews - Serious Incidents/HSIB recommendations - MNVP feedback - Single delivery plan (Director of Midwifery) **Assurance Gap:** EPR with interoperability between maternity and neonates, aligned with national data reporting requirements and with patient access functionality **Action:** Delivery of maternity digital strategy (CDIO) – oversight by F&BPC **Assurance Gap:** Staffing levels **Action:** Recruitment workstreams (see CRR)

**See Committee framework for clarity in individual metrics*

2.2 Strategic Objective 2 Principal Risk; Failure to deliver our annual financial plan

Strategic Objective 2	**To deliver a financially sustainable plan and improve our benchmarking in model hospital**			
Achieve by 2025…	**We will continuously improve our services and use of resources to deliver value of our residents**			
Strategic Priority	Provide outstanding, high value care ("Outstanding Care")			
Principal Risk	2. Failure to deliver our annual financial plan.			
Executive Lead	Chief Finance Officer		**Oversight Committee**	Finance & Business Performance Committee – last review March 2024
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**	
Impact 3 Likelihood 5 **Total Score 15**	Impact 3 Likelihood 4 **Total Score 12**	**Minimal-Cautious (2-3)**	CRR 234	Delivery of the 2023/24 Financial Plan – **currently under review**
			CRR 224	Trust capital resourcing insufficient to support objectives – **currently under review**
Last Review	Chief Finance Officer 23 April 2024 – **currently under review**			
Movement in Risk	None			

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls? What level is this assurance?*	**Action Required** *Where are our gaps in assurance? What actions are required?*
Underlying organisational financial deficit Fixed envelope funding model Lack of long-term financial strategy Structural financial challenges Mismatch demand and availability of Trust level capital Inability to improve organisational productivity to pre-pandemic levels and above Inflationary pressures	- Negative impact on ICS financial position. - Reduced opportunities for service investment. - Block contract for locally commissioned services which does not reflect the increasing cost of meeting regulatory standards. - Inability to plan resourcing long term, to deliver strategic plans and activity at required levels. - Inability to invest in estates and digital improvements. - Inability to support structural shifts in activity between care settings (hospital to community).	- Scrutiny from CMG/EMC, Finance and Business Performance Committee, Trust Board including; in-year financial performance, variance analysis, efficiency programme etc - Care Group & Corporate Performance Reviews and finance/workforce (??)-Reporting/challenge of performance through NHSE Regional, ICB/ICS and APC - Budget setting and monitoring processes. - Continual engagement with NHSE and ICB regarding inherent risks and management of these. - Continue to seek alternative funding solutions to address the capital funding gap. - Financial governance framework in place. - Agreed 2024/25 financial plan through Trust Board and submitted to ICB/NHSE. - Weekly executive review and challenge sessions on workforce/efficiency.	- Budget setting and monitoring processes in place (1). - Monthly finance reports (1). - Monthly monitoring of CIPs (1). - Outputs of relevant meetings including minutes of F&BPC, Transformation Board, CMG (1). - Financial deep dives (2) – *to focus on Trustwide issues e.g. Patient Flow/Urgent Care Workstream, rather than Care Group specific issues.* - Output of performance reviews meetings for financial deep dives (2). - Commercial strategy (2). - Meetings between CFO and Regional NHSE representative on month end position; outputs of meeting (3). - Fortnightly system meetings; providers and ICB (3). - Oversight of Commercial Strategy through F&BPC (2). ASSURANCE LEVEL **MEDIUM**	**Assurance Gap:** Historic issues underpinning organisational deficit to be addressed as part of joint external review with ICB. **Action:** Plan to address the deficit as part of annual and medium-term planning (CFO) – Planning update to Board 28 February 2024. **Assurance Gap:** Historic issues underpinning organisational capital deficit. **Action:** Need to pursue alternative external capital provision (eg. PFI bullet payments, MES and Asset Sales) – to complete by March 2024.

2.3 Strategic Objective 3 Principal Risk; Failure to work effectively and collaboratively with external partners

Strategic Objective 3	**Work with our partners and engage people**

Strategic Priority	Take a leading role in our community (“Healthy Communities”)				
Principal Risk	3. Failure to work effectively and collaboratively with external partners				
Executive Lead	Chief Digital & Transformation Officer		**Oversight Committee**	Trust Board	
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**		
Impact 4 Likelihood 5 **Total Score 20**	Impact 3 Likelihood 3 **Total Score 9**	**Open (4)**	n/a	n/a	
Last Review	Director of Strategic Programme Delivery 9 April 2024 Chief Digital & Transformation Officer 9 April 2024				
Movement in Risk	None				

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
Inability to work with partners to deliver new models of proactive and preventative care Failure to align with Council and Partners for Place Strategy Local uncertainty Failure to secure necessary infrastructure changes linked to Buckinghamshire growth strategy Not realising Trust potential as an anchor institution	- Missed opportunities to develop new models of care to improve patient experience and outcomes - Impact on public trust/ confidence - Services not aligned to community needs. - Duplication of services and not making full potential of public money - Population health outcomes deteriorate or do not improve - Health inequalities widen	- CEO participating in ICS Senior Leaders Group & Chair in ICS Chairs Group. - Integrated Programme Board established; oversees governance of integration work and new model for discharge – co chaired by DCOO. - Acute Provider Collaborative (new models of elective care) - New arrangements for Integrated Partnership Board (joint CEO for decision making) - Participating in Buckinghamshire Executive Partnership (BEP) – Place Based Board chaired by CEO and attended by COO. Health and Wellbeing (HWB) Strategy agreed with dedicated Trust leads for each element. -Participating in Opportunity Bucks Board and relevant subgroups - Pathology Network - Thames Valley Radiology Network; Attend by COO - Access to proposals for housing developments including responses in terms of health impact - Bucks ICP Estates Group. - Involvement with Bucks dev. plans. - Playing an active role in community; support for local voluntary and community groups to foster engagement. - S106 Proforma in place (collaborative working with Bucks Council)	- MoU in place for Provider Collaborative (3). - Outputs of Partnership Board and Programme Board (3). - MoU in place for Pathology Board, Trusts signed up to LOAs (3). - Annual report for Thames Valley Network. MoU and LOAs in place. Signed up to workforce strategy (3). - Regional funding secured by networks and disseminated to Trusts (3). Database access & outputs (3). - One Public Estate Strategy (2). - Outputs of System meetings (2). - Contracts and specifications (2). - PPEDI group records (2). - Buckinghamshire Health and Wellbeing Strategy ASSURANCE LEVEL **MEDIUM**	**Action:** Process in place to review clinical strategy taking a Buckinghamshire wide strategy, including BEP partners and VCSE sector. **Action**: BEP developing a delivery group to focus on delivering BEP priorities.

2.4 Strategic Objective 4 Principal Risk; Failure to provide consistent access to high quality care for Children and Young People

Strategic Objective 4	**Ensure children get the best start in life**
Strategic Priority	Take a leading role in our community (“Healthy Communities”)

Principal Risk	4. Failure to provide consistent access to high quality care for Children and Young People (CYP)			
Executive Lead	Chief Nurse		**Oversight Committee**	Quality & Clinical Governance Committee – last review February 2024
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**	
Impact 5 Likelihood 5 **Total Score 25**	Impact 4 Likelihood 3 **Total Score 12**	**Minimal-Cautious (2-3)**	n/a	n/a
Last Review	SDU Lead 08 August 2023 Chief Operating Officer – **currently under review**			
Movement in Risk	None			

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls? What level is this assurance?*	**Action Required** *Where are our gaps in assurance? What actions are required?*
Shortage of Community Paediatricians Waiting times for community paediatric services Space restrictions; lack of MDT appropriate clinical space within multiple sites Ability to manage current demand whilst reducing backlog Lack of digital solution for repeat prescriptions	Services do not provide care in a timely manner - Potential harm - Negative experience	- Scrutiny of Children and Young People (CYP) community services by QCGC Committee. - SEND written statement of action, scrutinised by CQC and OFSTED. - Scrutiny by Commissioners (monthly). - PilotMDT working model. - SDU Lead in place. - Deputy Divisional Director in place directly working with CYP. - Recruitment of two pharmacists - Ongoing recruitment efforts for Psychologist, GP, Specialty Doctor, therapists. - Working with The Owl Centre & Helios; outsourcing waiting list. - Tight criteria and triage for referrals. - Text messaging reminders for appointments. - Patient Initiated Follow Up (PIFU) in place. - Maintaining communication with families. - Clinical validation of waiting list. - Cohorting of waiting list following validation. - Review to Discharge processes in place to reduce follow up appointments. - Short notice waiting list in development for appointment utilisation. - Embedded harm review process. - Escalation of estates issues via COO.	- Outputs of relevant meetings (level 1). - SEND report (3). - SEND action plan, oversight by QCGC (2). - Evaluation of MDT working model (interim) (1). - Monthly reporting at service and divisional level, including minutes of meetings (1). - Monthly reporting to Commissioners (1). - Suite of letters to families re: waiting times (1). - Outputs of harm review process (1). ASSURANCE LEVEL **MEDIUM**	**Assurance Gap:** Estates plan for relocation of therapies at SMH **Action:** Redesign of therapy services (including those for children) – redesign buildings to facilitate this across Buckinghamshire **Assurance Gap:** Inability to commit to MDT working model **Action:** Estates solution at Rayners Hedge, Haleacre & Wycombe Hospital. **Assurance Gap**: Digital immaturity within services **Action**: Explore options for digital solution with corporate teams (SDU Lead) – update November 2023 **Action:** Tender for children's services (completion date TBC)

2.5 Strategic Objectives 5 & 6 Principal Risk; Failure to support improvements in local population health and a reduction in health inequalities

Strategic Objective 5	**Use population health analytics to reduce health inequalities and improve outcomes in major disease**
Strategic Objective 6	**Improve the wellbeing of communities**
Achieve by 2025…	**We will prevent people dying earlier than they should, with a particular focus on addressing inequalities in access and outcomes**
Strategic Priority	Take a leading role in our community ("Healthy Communities")

Principal Risk	5. Failure to support improvements in local population health and a reduction in health inequalities				
Executive Lead	Chief Digital & Transformation Officer		**Oversight Committee**	Finance & Business Performance Committee – last review March 2024	
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**		
Impact 3 Likelihood 4 **Total Score 12**	Impact 3 Likelihood 3 **Total Score 9**	**Open** **(4)**	n/a	n/a	
Last Review	Director of Strategic Programme Delivery 9 May 2024 Chief Digital & Transformation Officer 9 May 2024				
Movement in Risk	None				

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
Inequalities in access to care and outcomes of care Failing to use integrated care records and data to manage population health Failure to take population health inequalities into account when making decisions about care delivery and the use of resources Not realising Trust potential as an anchor institution Failure to work in an integrated way with partners	- Continued growth of the health inequality gap - Preventative health strategies and clinical services not aligned to community needs - Some group continue to receive less care relative to their needs -Some groups continue to have poor experiences, outcomes and health status - Demand for health care (particularly Urgent and Emergency Care) will increase	- Equality impact assessments. - Index of Multiple Deprivation data. - Patient and Public Equality Diversity and Inclusion (PPEDI) group. - Use of protected characteristics/geography in reporting for e.g., complaints/serious incidents. - Waiting list delivery assessment by ethnicity. - Increase information recorded on and access to Shared Care Record (SCR). - Reporting/benchmarking on population health management. - Health and Wellbeing (HWB) Strategy agreed with dedicated Trust leads for each element. - Appointment of substantive Director of Strategic Programmes Delivery. - Collaboratively working with partners through Opportunity Bucks and Buckinghamshire Executive Partnership (BEP) - Development of Health Inequalities Dashboard -Healthy Communities Programme - In house inpatient and maternity tobacco dependency service in place - Homeless clinic - Participating in Health Inequalities Leaders Buckinghamshire group	- EQIA policy (1). - EQIA documents within service change/business cases (1). - PPEDI review of EQIA process (2). - Deprivation & ethnicity reporting within monthly IPR (1). - Meeting notes/actions from PPEDI meetings (1). - Public health reporting/benchmarking (3). - Patient Experience annual report (1). - SCR utilisation reports (2). - Public health reporting (3). - HWB Place-based strategy (3). - Minutes from Levelling Up Programme Board (Opportunity Bucks and BEP (1). - Papers and actions from Healthy Communities Programme (1). -Healthy Communities breakthrough metrics (2) - Tobacco Dependency service activity figures (2) ASSURANCE LEVEL **MEDIUM**	**Assurance Gaps:** - Consistency in EQIA completion. - Facilitation of simple access to SCR for clinicians. **Action:** SCR working group established in February to ensure access for direct delivery of care and ensuring analytical skills required to analysis population health is in place. - Clear understanding of link between Trust actions and outcomes **Action:** Roll out of Health inequalities Dashboard to care groups to enable understanding of inequalities at service level and development of action to reduce. **Action:** Share PHM data across leadership team to ensure understanding, including through strategy development. **Action**: Ensure Health Inequalities are considered as part of QI approach **Action:** Review of Trust clinical strategy commenced, developing a place wide approach **Action:** Roll out use of SCR to proactively manage patients including pre-operative optimisation **Action:** Ensure place wide develop of SCR including adding additional health and social care data. **Action: F**urther roll out use of connected care for clinical services i.e. Tobacco Dependency Team now seeing patients from connected care, using segmentation tool to support waiting list management.

2.6 Strategic Objective 7 Principal Risk; Failure to deliver our People priorities

Strategic Objective 7	**Deliver our people priorities**			
Achieve by 2025…	**Our people will feel motivated, able to make a difference and be proud to work at BHT** **We will attract and retain talented people to build high performing teams with caring and skilled people**			
Strategic Priority	Ensure our workforce are listened to, safe and supported ("A Great Place to Work)			
Principal Risk	6. Failure to deliver on our people priorities related to recruitment & resourcing, culture & leadership, supporting our staff, workforce planning & development and productivity.			
Executive Lead	Chief People Officer		**Oversight Committee**	Strategic People Committee – last review March 2024
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**	
Impact 4	Impact 4	**Minimal**	CRR 51	Shortage of nursing staff; registered and unregistered

Likelihood 4 **Total Score 16**	Likelihood 3 **Total Score 12**	**(2)**	CRR 189	Risk of Industrial Action
			CRR 287	Midwifery Staffing
Last Review	Chief People Officer 20 May 2024			
Movement in Risk	None			

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
Insufficient levels of qualified, experienced staff and training opportunities. Cost of living (nationally) Impact on morale, wellbeing and retention resulting from the pandemic, sustained operational pressures and industrial action Variations in organisational culture and behaviours including staff reporting bullying and harassment. Workforce not always feeling the organisation is safe including staff reporting incidents of violence and aggression from patients, families and service users. Organisation is not always inclusive and does not always treat people equally Significant and sustained operational demand Industrial action (IA)	- Retention challenges - High levels of temporary staffing. - Low staff resilience and wellbeing negatively contributing to engagement, productivity, happiness at work and potentially the quality of care provided - Higher than optimal levels of bullying - Negative impact on staff engagement and productivity - Reputational damage. - Consequential impact on patients care.	- Trust-wide recruitment and retention plans in place (international, national and grow-your-own). - Bucks Health & Social Care Academy facilitating non-medical career pathways. - NHS Professionals partnership contract to support bank fill rather than agency. - Regional system programme to develop sustainable system approach to management of temporary staffing - BOB ICS Senior Leadership Group. - Comprehensive cost of living support package. - Comprehensive in house OH & Wellbeing offer with external referral as appropriate - Staff reporting of sickness ESR. - Trust sickness absence management policy. - Comprehensive vaccination programme. - Regular JMSC & JCNC meetings. - Staff networks (SNs) in place. - Monthly ED&I committee including SN chairs. - Opportunities for staff to feel listened to; listening meetings. - FTSUG including outreach model. - Weekly MDT forum to follow up incidents of violence and aggression. - Health & Safety Committee provides opportunity for staff feedback. - WRES and WDES actions. - Involvement of unions in policy development. - Supporting skill mixing to cover for IA. - Targeted support for colleagues affected by ongoing IA (awaiting outputs).	- Monthly reporting on vacancy rates, sickness rates and OH referrals through IPR (level 1). - International recruitment programme reported through Transformation Programme (level 1). - Divisional performance reports including bank and agency spend (level 1). - Contract management with NHSP to ensure quality of temporary staff (level 2). - ESR reporting (level 2). - FTSUG reporting (level 2). - GSWH reporting (level 2). - Annual staff survey (level 3). - Quarterly Pulse survey (level 3). - Monthly reporting through Transformation Board (level 1). - Outputs of relevant meetings (level 1). - Risk registers (level 2). - WRES/WDES action plans (level 3). - PSED annual reports (level 3). - EQIAs (level 2). - Papers to SPC and Board (level 1). - Gender Pay Gap reporting (level 2). - ICS People Strategy (level 2). - Safe staffing reports; (level 1). ASSURANCE LEVEL **MEDIUM**	**Assurance Gap:** Inequal experience for BME colleagues. **Action**: As per WRES action plans; monitored through SPC. **Assurance Gap:** Difference in experience across Trust - Identified through Staff Survey; feeds into Divisional Risk Registers where appropriate. **Action**: As per risk registers. **Assurance Gap:** Consultants accepted new pay deal. Junior doctors entering mediation with government. SAS doctors balloting on latest offer (31 May – 14 June) Industrial action for both groups on hold during above.

2.7 Strategic Objective 8 Principal Risk; Failure to provide adequate buildings and facilities

Strategic Objective 8			**Our buildings and facilities will be great places to work and contribute to the health and wellbeing of staff**	
Strategic Priority			Ensure our workforce are listened to, safe and supported ("A Great Place to Work)	
Principal Risk			7. Failure to provide adequate buildings and facilities. a) Estates b) Digital	
Executive Lead			Chief Commercial Officer (Estates) Chief Digital & Transformation Officer (Digital)	**Oversight Committee** Finance & Business Performance Committee* – last review March 2024 Strategic Workforce Committee* – last review March 2024
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**	
Impact 4 Likelihood 4 **Total Score 16**	Impact 4 Likelihood 4 **Total Score 16**	**Cautious (3)**	CRR 225	Risk of disruption to Trust technology through cyber incidents
			CRR 190	Interior condition of ward 2a; CQC regulation compliance
			CRR 184	Wycombe Tower interior; suitability for provision of healthcare

Last Review	Chief Digital & Transformation Officer 9 April 2024 Chief Estates & Facilities Officer – **currently under review**	CRR 415 CRR 410	New Wing Theatre Block (SMH) not able to meet accreditation standards Marlow & Wycombe Theatres (WH) not able to meet accreditation standards
Movement in Risk	None		

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
7a. Estates				
Lack of capital Ageing estates	- Low compliance with regulatory requirements - Staff leave due to feeling unsafe. - Loss of confidence of public in care received.	- Estates and Net Zero Strategy - Clinical strategy - QFM – prioritise through this. - PFI contracts; facilities management - Accommodation strategy - CMG prioritisation process (use of capital for critical areas)	- Annual reports; H&S, Fire, Security (level 1). - Property services report (level 1). - PAM report (level 2). - Strategy updates (level 1). - Minutes of CMG (level 1). - Compliance with legislation (level 2). - PLACE assessments (level 3) - Model Health System (level 3) - ERIC returns (level 3) - H&S Dashboard (level 2)	**Assurance Gap:** Significant backlog maintenance within the estate Lack of available capital to mitigate all issues
7b. Digital				
Digital immaturity leading to service disruption and preventing wider service transformation Lack of detailed intelligence to drive quality improvement initiatives	- Low compliance with regulatory requirements - Continued reliance on paper based/manual information flows - Lack of data limits potential improvements - Potential clinical harm (lack of EPMA)	- DSPT audit. - Extensive existing IT stabilisation programme - IT Performance monitoring.	- Reporting against DSPT to EMC, FBPC and Board quarterly (level 2). - Digital strategy in place (level 1). - Outputs from relevant meetings (level 1). - EPR readiness review (level 3). ASSURANCE LEVEL **MEDIUM**	**Assurance Gap:** Gaps in infrastructure and unsupported systems. **Action:** Updating systems to comply with cyber standards (monitored through DSPT) **Assurance Gap:** Stabilisation of IT infrastructure and modernisation of apps to be completed. **Action:** (CDIO) – as per CRR Risk 225

2.8 Strategic Objective 9 Principal Risk; Failure to learn, share good practice and continuously improve

Strategic Objective 9	**Maximise opportunities for improving, sharing good practice and learning**			
Strategic Priority	Ensure our workforce are listened to, safe and supported ("A Great Place to Work)			
Principal Risk	8. Failure to learn, share good practice and continuously improve.			
Executive Lead	Chief Medical Officer		**Oversight Committee**	Quality & Clinical Governance Committee – last review February 2024

Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**	
Impact 3 Likelihood 4 **Total Score 12**	Impact 3 Likelihood 3 **Total Score 9**	**Open** **4**	n/a	n/a
Last Review	Head of Medical Quality – 8 April 2024			
Movement in Risk	None			

Strategic Threats	**Effect**	**Existing Controls**	**Assurance Record**	**Action Required**

What might cause this to happen?	*What might the effect be?*	*How are we managing the risk?*	*What evidence do we have for the effectiveness of the controls? What level is this assurance?*	*Where are our gaps in assurance? What actions are required?*
Gaps in learning following incidents or against best practice Not being an organisation where innovation and new ideas can always thrive and be easily adapted	- Missed opportunities to improve patient outcomes/experience. - Non-systematic approach to learning. - Inefficiencies, processes not completed in a timely manner, erosion of desire to innovate and improve. - Inadequate foresight of organisational risk. - Inability to transform care and clinical models in a way that is fit for the future.	- Reflect and Review learning forum (monthly) - Monthly reporting on Serious Incidents - Nursing Learning forum - Patient safety meeting (monthly) - Upgraded Datix risk management platform - Analysis of Datix reports (weekly, monthly) - Weekly review panel for Serious Incidents - Board and Committee workplan. - Benchmarking. - Board and Committee structures. - Review of governance framework. - Innovation centre; hub for R&I teams and space for teams to come together and share good practice. - Digital infrastructure upgrades. - Roll out of QI programme. - Executive Dashboards in place. - Implementation of Patient Safety Incident Response Framework (PSIRF).	- SI reports, meeting minutes and actions (level 1). - Meeting notes/actions from patient safety meeting (level 1). - Outputs of relevant meetings (level 1). - Outcomes of external reviews (level 3). - External governance report (level 3). - R&I Strategy (level 1). - QI plans (level 1). - Quality Strategy (level 1). - R&I Annual Report (level 1). - Regular reporting on PSIRF delivery plan to EMC and Q&CGC (1). ASSURANCE LEVEL **MEDIUM**	**Assurance Gap:** Inability for Datix to identify trends within reporting (not possible on the upgraded version) **Action:** We are currently transitioning to PSIRF and will be adding system thematic categories to Datix to monitor incident trends and identify learning as part of the PSIRF plan. Currently, thematic analysis is carried out manually.

3.0 Emerging Risks; Board & Board Committees

Month	Meeting	Risks Noted
Mar 2024	**Audit**	- Impact of GNRI (Goods Received Not Invoiced).
	F&BP	- Variance to the Trust 2023/24 financial outturn (£1.6m). - Current system financial position and resultant increase in oversight/scrutiny. - Current pay run rate and potential impact on 2024/25 financial performance.
	Q&CG	- Measles cases. - Ongoing challenge in providing tissue viability services within care homes. - Ongoing increase in demand for safeguarding services; both adults and children. - Poor scoring related to cleanliness, recognised both locally and nationally.
	SPC	- Related to the ED&I report and the 2023 Staff Survey results, the need to focus on intersectionality of colleagues. - Actions related to the Temporary Staffing Programme; recognising oversight of the outputs and financial implications of this by the Finance & Business Performance Committee.

	Public Board	- Emerging financial position of the Trust and System.
	Private Board	No new emerging risks identified.
Apr 2024	**Q&CG**	- Potential patient safety risk related to rise in incidences of pressure ulcers. - Immunisation status of contractors working in high-risk clinical areas
	F&BP	- Internal and external challenges in finalising and delivering the 2024/25 operational plan.
	Public Board	No new emerging risks identified.
	Private Board	- Internal and external challenges in finalising and delivering the 2024/25 operational plan. - Disconnect between system priorities and income allocation.

For those risks highlighted in the above table (not reflected in the BAF or CRR), the table overleaf pulls together actions held by the Board and Committees where these have been set to address these risks.

Risk(s)	Action Details	Committee Matrix	Action Owner	Due Date
Potential patient safety risk related to rise in incidences of pressure ulcers.	Deep dive to be presented to the Committee.	Quality & Clinical Governance Committee	Chief Nurse	May 2024

4.0 Action required from the Board / Committee

The Board is requested to:

a) Review the range of risks and use the information to inform strategic decision making.
b) Consider the assurances in place, identifying gaps in controls/assurances and challenge these accordingly, identifying further actions required as appropriate.
c) Review the emerging risks identified at Board and Board Committee meetings and consider reflection of these within the current BAF and CRR, paying attention to those not within these frameworks and the actions in place to mitigate.

5.0 Heatmap – Residual Risk

Catastrophic (5)					
Major (4)			4. Failure to provide consistent access to high quality care for Children and Young People (CYP) 6. Failure to deliver on our people priorities	7. Failure to provide adequate buildings and facilities.	

Moderate (3)			3. Failure to work effectively and collaboratively with external partners 5. Failure to support improvements in local population health and a reduction in health inequalities 8. Failure to learn, share good practice and continuously improve	1. Failure to provide care that consistently meets or exceeds performance and quality standards. 2. Failure to deliver annual financial and activity plans	
Minor (2)					
Negligible (1)					
	Rare (1)	**Unlikely (2)**	**Possible (3)**	**Likely (4)**	**Almost Certain (5)**

6.0 Risk Appetite Statement

Buckinghamshire Healthcare NHS Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners.

The Trust has the lowest tolerance for risks that materially impact on the safety of our patients and colleagues and we will not accept these. We recognise that decisions about our level of exposure to risk must be taken in context but are committed to a proactive approach. We have a greater appetite for risk where we are persuaded there is potential for benefit to patient outcomes/experience, service quality and/or value for money. The Trust has the greatest appetite to pursue innovation and challenge current working practices where such positive gains can be anticipated whilst operating within appropriate governance arrangements and regulatory constraints.

Where we engage in risk strategies, we will ensure they are actively monitored and managed and would not hesitate to withdraw our exposure if benefits fail to materialise. Our risk appetite statement is dynamic and its drafting is an iterative process that reflects the challenging environment facing the Trust and the wider NHS. The Trust Board will review the risk appetite statement annually.

7.0 Risk Matrix

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic

Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent Review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

RISK SCORING MATRIX					
	Severity				
Likelihood	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

Date: 29 May 2024

Agenda item	Annual Governance Statement
Board Lead	Neil Macdonald, Chief Executive Officer
Author	Joanna James, Trust Board Business Manager
Appendices	Annual Governance Statement 2023/24
Purpose	Approval
Previously considered	Audit Committee 09.05.2024

Executive summary

The Department of Health & Social Care (DHSC) Group Accounting Manual (GAM) requires NHS Trusts to include an Annual Governance Statement within their annual report. Guidance is issued by NHS England (NHSE) on the format of this and the requirements for submission are set out within the NHSE accounts and reporting timetable.

Attached is the draft Annual Governance Statement (AGS) for the financial year 2023/24. This was considered by Audit Committee on 9 May 2024. Amendments were suggested and subsequently included within the attached. These were non-material. The content of the AGS was approved by the Audit Committee including internal and external auditors. Subject to Board approval, the AGS will be included in the full and final Annual Report for 2023/24.

Decision	The Board is requested to consider and approve the AGS for inclusion in the 2023/24 annual report.

Relevant strategic priority

Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☒

Relevant objective

☐ Improve waiting times in ED ☐ Improve elective waiting times ☐ Improve safety through clinical accreditation	☐ Give children living in most deprived communities the best start in life ☐ Outpatient blood pressure checks	☐ Zero tolerance to bullying

Implications / Impact

Patient Safety	Governance arrangements related to patient safety are considered within the report.
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	The role of the BAF and the key risks faced by the organisation in achieving the strategic objectives are summarised within the report.
Financial	Financial governance arrangements are considered in the report.
Compliance NHS Regulation	As per the above, an Annual Governance Statement is a requirement of the DHSC.
Partnership: consultation / communication	The Annual Report and Annual Governance Statement have been produced through collaborative working with internal teams, the Audit Committee and auditors.

Equality	Governance related to equality matters is considered within the report.
Quality Impact Assessment [QIA] completion required?	n/a

Corporate Governance Report

Directors Report

Trust Board

The Trust Board provides strategic leadership to the organisation. It sets the strategic direction, fosters the appropriate culture, monitors performance and ensures management capability and capacity. It outlines the vision of the organisation, championing and safeguarding its values, keeping the safety of patients at the centre of its work and ensuring obligations to all key stakeholders are met. By ensuring the effective and efficient use of resources it safeguards public funds.

Together, the Trust Chair and the Chief Executive set the tone for the whole organisation and are ultimately responsible for ensuring that the population the Trust serves, and the wider system in which the Trust sits, receive the best possible care in a sustainable way. The Chair is responsible for the effective leadership of the Board and is pivotal in creating the conditions necessary for overall Board and individual director effectiveness. The Senior independent Director (SID), an appointed Non-Executive Director, has a key role in supporting the Chair in leading the Board. The SID is also positioned to act as intermediary for other directors when necessary and leads non-executive directors in oversight of the Chair, for example, through leading the annual appraisal process. In contrast to the more strategic role of the Chair, the Chief Executive leads the Executive Directors in the delivery of the Trust's strategy and objectives through implementation of appropriate resources and risk management systems.

Executive and Non-Executive Directors both have responsibility to constructively challenge the decisions of the Board. Non-Executive Directors have a particular duty to hold the Executive Directors to account, ensuring appropriate challenges are made. As well as bringing their own expertise to the Board, Non-Executive Directors scrutinise the performance of management in reaching goals and objectives and monitor the reporting of performance. They need to satisfy themselves as to the quality and integrity of financial, clinical and other information, and ensure that the internal controls of risk management are robust.

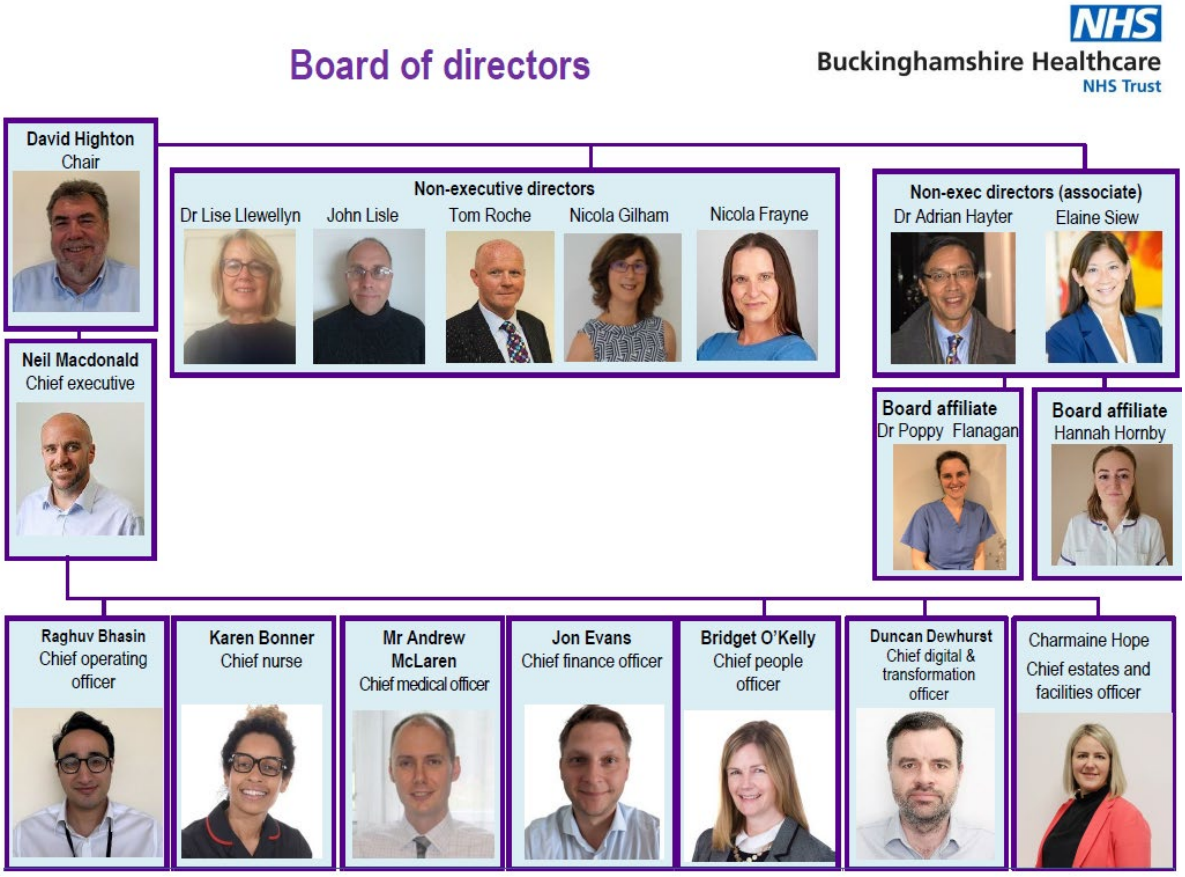
Further details on all Board members including biographies are available on the Trust website. www.buckshealthcare.nhs.uk/our-organisation/our-trust-board/

The Trust Board meets at least 10 times per year in public, details of which are available in advance on the Trust's public website which also contains agendas, minutes and reports. www.buckshealthcare.nhs.uk/our-organisation/our-trust-board/

The Trust Board formally operates within its Terms of Reference, the Trust's Standing Orders, Scheme of Delegation and Standing Financial Instructions. These can also be found on the Trust website. www.buckshealthcare.nhs.uk/documents/governance-manual/

The maintenance of an effective Board is supported by the Trust Board development programme with seminars on key themes held on a monthly basis. During 2023/24 these included the Opportunity Bucks programme, strategic risk management, improvement approaches, health inequalities and workshops related to the delegation of statutory functions, the urgent and emergency care (UEC) improvement plan and redevelopment of the Wycombe site. In February 2024, the Trust's Trainee Leadership Board presented their work on reducing hospital encounters.

Our Board members in 2023/24 and their roles are shown below:



The following changes took place during 2023/24:

Non-Executive Directors

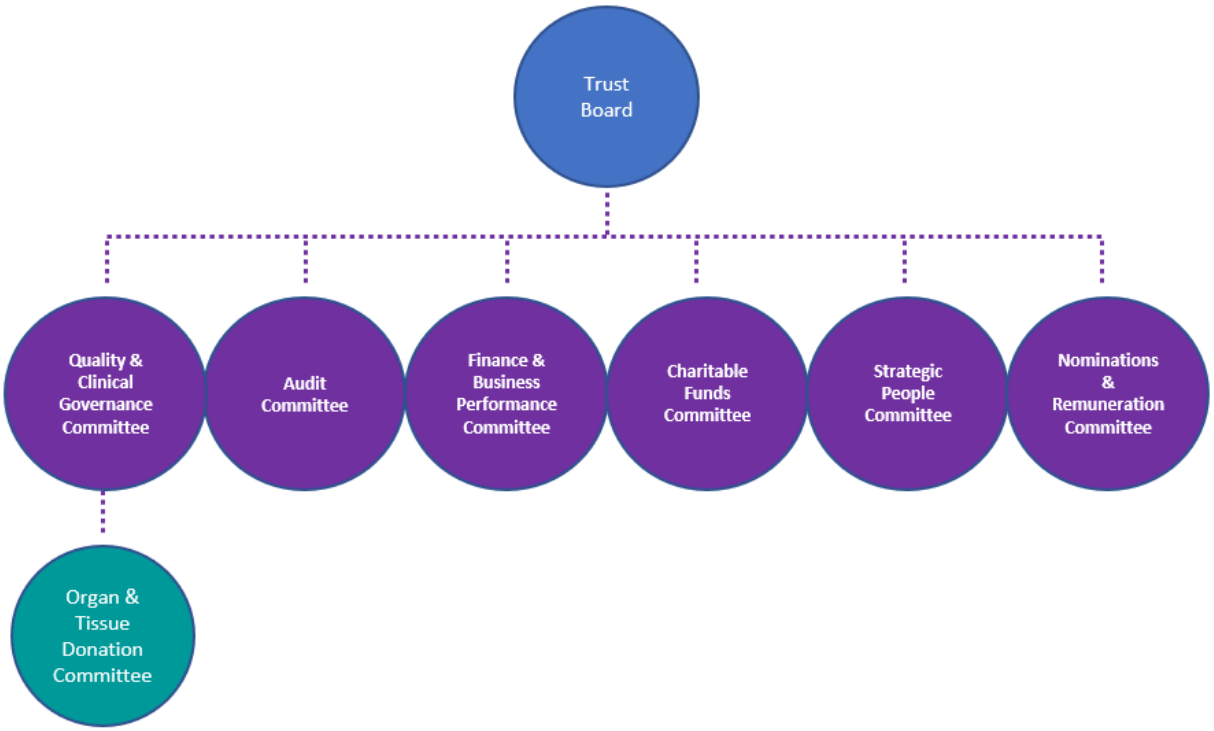
- Rajiv Jaitly and Dipti Amin stepped down from their roles on 14 June 2023. Both were at the end of an eight-year term.
- Lise Llewellyn and Nicola Frayne joined the Board as Non-Executive Directors on 15 June 2023 and 11 July 2023 respectively.
- Elaine Siew joined the Board as an Associate Non-Executive Director on 3 October 2023 to replace Mo Girach, Associate Non-Executive Director, whose two-year term ended on 28 February 2023.
- Dr Sarah Lewis' term as (medical) Board Affiliate ended on 31 March 2024. Dr Poppy Flanagan joined the Board in her place on 1 April 2024.

Executive Directors

- Jon Evans joined the Board on 17 July 2023 as Chief Finance Officer in place of Kishamer Sidhu, Interim Chief Finance Officer.
- Ali Williams left her role as Chief Commercial Officer on 31 January 2024.
- Charmaine Hope joined the Board on 4 March 2024 as Chief Estates & Facilities Officer.

Trust Board Committees

The figure overleaf highlights the structure of the Board and its Committees.



A governance framework and associated processes are in place across the organisation to ensure that information flows clearly to the Board, providing assurance where possible and highlighting risks identified through gaps in control or gaps in assurance. The structures around governance and performance are currently undergoing a review.

The Board has delegated scrutiny of assurance process relating to workforce, quality and finance to four Committees:

- Audit Committee
- Finance & Business Performance Committee
- Quality & Clinical Governance Committee
- Strategic People Committee.

The Committees work together to provide an integrated approach to governance which is supported by common membership of Board members across the committees. Each has a Non-Executive Director as Chair and Non-Executive Directors form part of the membership. Each of the Committees has Terms of Reference and a plan of work which are reviewed annually and used as the basis of an annual assessment of Committee effectiveness.

There are two other Board Committees which are also described below:

- Nominations and Remuneration Committee
- Charitable Funds Committee.

Audit Committee

This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This, therefore, incorporates reviewing governance, risk management and internal control (plus the Board Assurance Framework) and oversight of the Internal and External Audit and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014.

In 2023/24 the Committee was chaired by Rajiv Jaitly, Non-Executive Director and Senior Independent Director between April-June 2023. From July 2023, John Lisle, Non-Executive Director became the Committee Chair. Between April-June 2023, four other Non-Executive Directors were also members; Dr Dipti Amin, Nicola Gilham, John Lisle and Tom Roche. From July 2023 onwards, Nicola Gilham, Tom Roche, Dr Lise Llewellyn became the Non-Executive members of the Committee.

Finance & Business Performance Committee

The purpose of the Finance & Business Performance Committee is to provide the Board with assurance concerning all aspects of financial, commercial and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. It provides the Trust Board with assurance that the financial issues of the Trust are being appropriately addressed, and with information and recommendations on key issues. The Committee also has oversight of the Trust's performance management framework and, as required, focuses on specific issues where the Trust is experiencing challenges with its operational performance.

During 2023/24, the Committee met monthly and was chaired by Nicola Gilham, Non-Executive Director.

Quality & Clinical Governance Committee

The Committee provides the Board with assurance concerning all aspects of quality relating to the provision of care and services in support of getting the best clinical outcomes, ensuring safety, and providing the best experience for patients. It assures the Board directly and through consultation with the Audit Committee that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health services. It also assures the Board that where risks and issues exist that may jeopardise the Trust's ability to deliver excellent quality healthcare, these are being managed in a controlled and timely way.

During 2023/24 the Committee met monthly. Between April-June 2023, the Committee was chaired by Dr Dipti Amin, Non-Executive Director. From July 2023 onwards, Dr Lise Llewellyn chaired the Committee.

Strategic People Committee

The Strategic People Committee aims to provide assurance to the Board in the areas of workforce development, planning, performance, engagement, equality, diversity and inclusion and assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high-performing and motivated workforce that is supporting business success. The Committee also receives assurance around health and safety processes and compliance. Reports from the Trust's Freedom to Speak up Guardian (FTSUG) set out activity, learning and resulting actions.

The Committee was chaired by Tom Roche, Non-Executive Director, in 2023/24 and it met on a bi-monthly basis.

Nominations & Remuneration Committee

On behalf of the Trust Board this Committee reviews the appointment of Executive Directors and other staff appointed on Very Senior Manager (VSM) contracts, to ensure such appointments have been undertaken in accordance with Trust policies. It also reviews the remuneration, allowances and terms of service of such staff; reviews (with the Chief Executive) the performance of Executive Directors and other staff appointed on VSM contracts; oversees appropriate contractual arrangements for such staff (including the proper calculation and scrutiny of termination payments, taking account of such national guidance,

as appropriate); and considers and approves proposals on issues which represent significant change.

The Committee meets as required and, during 2023/24, was chaired by David Highton, Trust Chair.

Charitable Funds Committee

This aims to ensure that the Buckinghamshire Healthcare NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors. This includes reviewing and agreeing the Charitable Fund Annual Report and financial accounts, for approval by the Trust Board.

In 2023/24 the Committee was chaired by Nicola Gilham, Non-Executive Director.

Further information on the Charitable Funds Committee and related activities can be found in the Charitable Funds Annual Report which is available via the Trust website. www.buckshospitalcharity.org/about/governance/

Executive Management Committee

Also important to the governance process is the Executive Management Committee (EMC) and its sub-committees. EMC is the key decision-making and risk committee. It is chaired by the Chief Executive and attended by the Executive team, Associate Director of Communications and a representative from the Care Group leadership triumvirates (Care Group Chair, Director of Operations or Director of Nursing).

Meetings of EMC enable key clinical and managerial issues to be discussed, developed, scrutinised, monitored and agreed and/or approved. Other senior leaders in the organisation attend as required. EMC is authorised to make decisions on any matter that is not reserved for the Trust Board or Board Committees in line with the Trust Standing Financial Instructions; key issues are reported to the Trust Board as part of the monthly report from the Chief Executive.

In addition to EMC, there are a range of other forums, structures and processes in place to oversee and manage any issues relevant to particular aspects of risk and governance.

Transformation Board

The Transformation Board was established to provide assurance that the Trust's transformation plans are delivered successfully and that associated benefits related to quality, people and finance are realised. The Transformation Board supports EMC in providing a dedicated forum for Executive Directors and the Care Group leadership triumvirates to discuss and debate such programmes alongside senior clinical and corporate colleagues and provides support and direction for escalated issues and risks to support delivery of plans.

Declarations of Interest

The Trust Board and Board Committees routinely ask that any interests relevant to the agenda items be declared at each meeting. In addition, a Register of Directors' Interests is maintained by the Trust Board Business Manager, presented to Board on an annual basis and published on the Trust website. www.buckshealthcare.nhs.uk/publications/reports-and-data/

Both recruitment processes and those related to the management of conflicts of interests support the maintenance of Non-Executive Director independence. Independent directors

are better able to make objective decisions and provide challenge and scrutiny to Executive colleagues.

Reports to the Information Commissioner's Office (ICO)

Information on personal data-related incidents where these have been formally reported to the ICO can be found in the Annual Governance Statement later in the Corporate Governance Report.

Statement of Directors' Responsibilities

Each Director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and has taken all steps that he or she ought to have taken to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Buckinghamshire Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Buckinghamshire Healthcare NHS Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Divisional Structure Review

During the summer of 2023, a proposal to revise the structure of the organisation was considered and approved resulting in the development of four 'Care Groups' in the place of the previous five 'Divisions' as per the table below.

Divisional Structure				
Integrated Medicine	Surgery & Critical Care	Specialist Services	Women, Children & Sexual Health	Integrated Elderly & Community Care
Acute non-elective services, medical specialties (acute & community), neurorehabilitation	Critical care, emergency & planned surgical care	National spinal injuries centre (NSIC), pharmacy, diagnostics, haematology, cancer performance, outpatients	Obstetrics, maternity, gynaecology, paediatrics (acute & community), sexual health	Medicine for older people (MFOP), therapies, community services
Care Group Structure				
Integrated Medicine	Surgery & Critical Care	Specialist Services	Community & Rehabilitation	
Acute non-elective services, medical specialties (acute & community), neurorehabilitation	Critical care, emergency & planned surgical care, outpatients, cancer performance	NSIC, pharmacy, diagnostics, haematology, obstetrics, maternity, gynaecology, paediatrics (acute)	MFOP, therapies, community services including community paediatrics, sexual health	

The objectives of the restructure were to provide both better care to patients and a better place for colleagues to work through the following:

- Bring together services and pathways currently spilt by divisional structures to allow greater alignment with the Trust strategy.
- Support closer working between services within and across different areas of the organisation.
- Create a more streamlined management structure across four, more evenly sized, care groups.
- Achieve a restructure with minimal change at service level to provide stability to the organisation during the year.

Alongside the restructure, a revised approach to the oversight of operational performance, risk management and quality governance was rolled out across the Care Groups. The new oversight framework is underpinned by a small set of key principles which support a focus on what matters, consistency and simplicity of information, clear lines of responsibility and accountability and a balanced approach to governance.

Capacity to handle risk

The Trust has a Risk Management Policy and a Risk Management Strategy, both of which are endorsed by the Board. The Risk Management Policy was last reviewed in 2022 and the Risk Management Strategy is currently under review.

The way in which leadership is given to the risk management process

Risk management is recognised as everyone's responsibility and all staff are expected to cooperate in the management of risk to maintain their own safety and the safety of all others in the organisation. The Risk Management Strategy sets out the corporate and individual accountability for risk management through the Trust Board and Board Committees as follows:

- The role of the Trust Board in reviewing the management of extreme risks; the Board receive details of these through regular reporting including that related to organisational risk, performance (through the integrated performance report) and finance.
- The role of the Audit Committee in monitoring the effectiveness of the system for managing risk; the Committee receive organisational risk reports including details of the Corporate Risk Register and Board Assurance Framework at every meeting and, through these reports, is able to provide assurance to the Board on the Trust's application of risk management processes.
- The role of the Finance, Quality and People Board Committees in monitoring risks pertaining to their purpose; these Committees regularly receive and consider the strength of assurance reflected within the risk management system and the actions being taken to manage risks.
- The role of the Executive Management Committee in moderating scores of those risks included on the Corporate Risk Register; the Committee reviews the Corporate Risk Register and the Board Assurance Framework and is responsible for challenging the effectiveness of operational risk management, moderating risks to ensure consistency and ensuring adequate controls are in place.
- The Risk & Compliance Monitoring Group in reviewing risk registers and making recommendations to the Executive Management Committee.

Board Committees are chaired by Non-Executive Directors and the Audit Committee, which has a pivotal role in providing assurance over risk management processes within the Trust, has a membership of only Non-Executive Directors. Through their position as Chairs and Audit Committee members, the Non-Executive Directors all have a responsibility to provide robust challenge to the executive management of risk and to seek reasonable assurance of adequate control.

The Chief Executive, as the Accountable Officer for the Trust, has overall responsibility for effective risk management in the organisation. The Trust Risk Management Policy sets out in detail the roles and responsibilities of the Chief Executive and other Executive Directors. These include the following:

- The Chief Nurse leads on the process for the strategic development and implementation of organisational risk management, is accountable for the development of strategic clinical risk and for ensuring there is a robust system in place for monitoring compliance with the Care Quality Commission (CQC) standards.
- The Chief Nurse is also the Director of Infection Prevention and Control for the Trust and, together with the Patient Safety Officer, is responsible for managing patient safety, complaints, patient information and medical legal matters.
- The Chief Finance Officer has delegated responsibility for maintaining financial controls including overseeing the adoption and implementation of the Standing Financial Instructions and is the lead for counter fraud. The Chief Finance Officer also liaises with Internal and External Audit services who undertake programmes of audit with a risk-based approach.
- The Chief Medical Officer is the Responsible Officer for Medical Revalidation.
- The Chief Operating Officer is the Accountable Planning Officer for Emergency Preparedness, Resilience and Response (EPRR)
- The Chief Digital & Transformation Officer is the Senior Information Risk Owner (SIRO). The SIRO is accountable to the Chief Executive with specialist support from the Information Governance team and Caldicott Guardian to ensure the management of confidentiality and security risks to Trust information and records.
- The Chief People Officer is accountable for the strategic management of the Trust's People strategy and equality and diversity compliance and employment processes.
- The Chief Estates & Facilities Officer has delegated responsibility for the management of Health & Safety risks and compliance with relevant legislation/regulation.

Collectively, the Executive Directors share responsibility for identifying and implementing control of strategic risks as well having individual accountability for risks within their specific portfolios. Each Executive Director will have governance mechanisms in place for the delivery and risk management of relevant services.

In addition, specific responsibilities are allocated to senior individuals within the organisation including:

- The Care Group leadership triumvirate (Care Group Chair, Director of Operational and Director of Nursing) share accountability to the Chief Operating Officer for identifying, managing and communicating risk within their respective divisions.
- The Trust Board Business Manager is the lead for the Board Assurance Framework on behalf of the Chief Executive.

- The Counter Fraud team is accountable to the Chief Finance Officer. The Local Counter Fraud Specialist (LCFS) undertakes the operational management and recording of fraud, bribery and corruption risks in the Trust.

The way in which staff are trained or equipped to manage risk in a way appropriate to their authority and duty

The Trust has a range of systems in place to prevent, manage and mitigate risks and measure associated outcomes. In addition to the Risk Management Policy, a comprehensive range of risk management policies and guidance are made available to staff including those related to incident reporting and investigation, risk assessment and health and safety.

Other measures in place to support colleagues in their ability to manage risks include:

- Risk-related training in specific areas as part of the corporate induction and mandatory training programme.
- Availability of advice related to the management of risk in specific areas from a range of in-house professional and specialist staff. In addition, certain types of risk are addressed by the engagement of external expertise. For example, the risk of fraud is managed and deterred by the appointment of an external Local Counter Fraud Specialist (LCFS).
- Clinical and corporate teams are encouraged to consider learning related to risk management from both internal and external sources. There are processes in place to share learning following reported incidents and best practice. A proportion of these will relate to how services predict and manage the elements of clinical and business risk that are a factor in the day-to-day delivery of healthcare services.
- The Trust has an embedded learning culture supported by excellence reporting which highlights key episodes of excellent work achieved by colleagues and is part of monthly reporting to the Trust Board. Such a culture is also supported by the implementation of national clinical standards, the delivery of improvements from local and national clinical audits, the Medical Examiner review of deaths process, and the focus on learning from all untoward incidents.
- An annual compliance with legislation activity is undertaken.

The risk and control framework

The key elements of the risk management policy

Risk management is described as the systematic identification, description, assessment and management of risk in a given context and all colleagues are expected to follow the processes outlined in the Risk Management Policy and utilise the incident reporting system.

Following identification, risks are scored using a standardised risk scoring matrix. Risks scoring 8 or above and new/emerging risks are reported at monthly Service Delivery Unit (SDU) governance meetings for inclusion in local risk registers. Risks scoring at 12 or above will be reported to divisional governance meetings for inclusion in care group risk registers. Risks scoring 15 or above will be reported monthly to the Risk and Compliance Monitoring Group. A similar process is followed for those corporate services sat outside of clinical divisions.

The Risk and Compliance Monitoring Group meets on a monthly basis and will make recommendations to the Executive Management Committee regarding risks to be escalated/de-escalated from the Corporate Risk Register. Urgent review of emerging or escalating risks are brought to the attention of the Associate Chief Nurse outside of these meetings by the Care Group Triumvirate.

On a bi-monthly basis, the Corporate Risk Register is presented to the Executive Management Committee and then onto Audit Committee and the Trust Board. Discussion at the Executive Management Committee will consider risks across the broader system and strategic risks, along with other known or emerging risks that may not yet be recorded. Where an operational risk has significant implications for delivering a Trust objective, this will be reflected in the Board Assurance Framework. The Corporate Risk Register is considered alongside the Board Assurance Framework at these meetings as part of a wider risk report which considers the current profile of risk across the organisation against the Trust's appetite for risk in each area.

The Quality & Clinical Governance, Finance & Business Performance and Strategic People Committees are presented with their profile risks on a regular basis throughout the year. These meetings have a significant role in gaining assurance in relation to risk management within the Trust, ensuring challenges at service level are discussed, supported and managed.

At the end of each Board and Board Committee meeting, the Trust Board Business Manager summarises the emerging risks; those that have been highlighted through reports received and discussions during the meeting. These triangulated with those risks within the Corporate Risk Register and Board Assurance Framework and presented to the Trust Board through the Committee Chair reports. Any risks not already reflected are presented to Audit Committee alongside meeting minutes with associated actions to ensure oversight of these.

The Risk Management Policy and Risk Management Strategy both describe the Trust Board's risk appetite statement which was considered last by the Board in June 2023 and is scheduled for review during the summer of 2024. The previous review was facilitated through an externally-led workshop and also involved setting an individual appetite for such risk to each of the strategic objectives and this information is displayed in the Board Assurance Framework report.

Buckinghamshire Healthcare NHS Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners.

The Trust has the lowest tolerance for risks that materially impact on the safety of our patients and colleagues and we will not accept these. We recognise that decisions about our level of exposure to risk must be taken in context but are committed to a proactive approach. We have a greater appetite for risk where we are persuaded there is potential for benefit to patient outcomes/experience, service quality and/or value for money. The Trust has the greatest appetite to pursue innovation and challenge current working practices where such positive gains can be anticipated whilst operating within appropriate governance arrangements and regulatory constraints.

Where we engage in risk strategies, we will ensure they are actively monitored and managed and would not hesitate to withdraw our exposure if benefits fail to materialise. Our risk appetite statement is dynamic and its drafting is an iterative process that reflects the challenging environment facing the Trust and the wider NHS. The Trust Board will review the risk appetite statement annually.

Trust Board Risk Appetite Statement, June 2022

The Trust has an established Board Assurance Framework (BAF) through which the Board is provided with a mechanism for satisfying itself that its responsibilities are being discharged effectively and informs the Board where the delivery of strategic objectives are at risk due to

gaps in control/assurance. During 2022, Board Assurance Framework reporting was reconfigured to align with the BHT Strategy 2025 strategic objectives and to reflect the relationship with the Corporate Risk Register and the oversight of principal risks by specific Board Committees.

Documented within the Board Assurance Framework for each of the principal risks are the strategic threats, potential effects should the risk materialise, controls and assurance records in place and any gaps in assurances with actions to address these. Inherent and residual risk ratings are presented alongside the Board's appetite for risk in that area. The Board Assurance Framework ensures that appropriate internal and external assurances are put in place in relation to the management of all high-risk areas and a level of assurance is provided for each of the risks.

Key elements of the quality governance arrangements

The Trust's quality governance arrangements are managed by the Quality & Clinical Governance Committee, it's sub-groups and committees and via a number of associated systems and processes.

Clinical audit is supported by a central team and the Quality & Clinical Governance Committee receives assurance on the design and the delivery of the clinical audit programme through a range of reporting including a quarterly update from the Clinical Effectiveness Group.

The investigation of incidents, and learning from these, has been predominantly managed within Care Groups and is discussed at specific governance meetings accordingly. Serious Incidents (SIs) have been discussed and monitored through the executive-led SI panels with the Trust Board maintaining monthly oversight of SIs through performance reporting and via the Quality & Patient Safety Group. Full details of maternity Sis are received by the Board quarterly. A wide range of mechanisms are in place to support learning from both incidents and the results of quality audits and these include:

- Chief Nurse- and Chief Medical Officer-led monthly newsletters and weekly bulletins highlighting the top quality and safety messages.
- A 'Reflect and Review' monthly forum for clinical and non-clinical colleagues to share examples of excellent patient care and examine areas for improvement.
- Academic half days.
- Formal and informal training and simulation sessions and experiential learning.

The Patient Safety Incident Response Framework (PSIRF) sets a new, mandatory, approach for the NHS to the development and maintenance of systems and processes for responding to patient safety incidents. The intention of this is to maximise learning and improvement from such incidents. During 2023/24 the Trust has been working to embed the new framework with a local PSIRF policy and implementation plan being approved both internally and by the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB). The Executive Management Committee and Quality and Clinical Governance Committee receive regular updates on progress against this plan.

Complaints are managed by the central complaints team in partnership with Care Group colleagues. The number of new complaints and percentage of complaints responded to within the required timeframe is considered monthly by the Trust Board. In March 2024, the Trust compliance with responding to complaints from the public within 25 days of receipt was 79% against a target of 85%.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). Compliance with these requirements has been ultimately assessed via CQC inspections and, during 2023/24, the Trust was subject to two such inspections. In June 2023, the Paediatric Emergency Department was inspected but not rated. The inspection was prompted by a concern raised by a member of the public. Later in June 2023, as part of the national maternity inspection programme, the CQC visited Maternity Services at the Trust which were rated as 'requires improvement'. The Trust has maintained its overall rating of 'good' following the wider inspection during February 2022. The Trust Board maintains oversight of the subsequent 'Must Do' and 'Should Do' CQC action plan which contains details of those actions arising from all of the above inspections.

During 2023/24, Internal Audit completed a review of the Trust CQC action plan including assurance processes and the test of collated evidence. This gained a reasonable assurance (positive) opinion.

Regular engagement meetings with CQC continued throughout 2023/24. Outside of formal inspections, the Trust monitors compliance with CQC registration requirements independently, primarily through a programme of regular in-house assurance visits/inspections. In 2022, the Clinical Accreditation Programme was launched and rolled out which measures and provides assurance on quality, safety, patient and colleague experience and leadership across the organisation. As of January 2024, a total of 60 clinical areas had been inspected with over half of those achieving 'silver' accreditation.

The CQC have now adopted a new single assessment framework which will be in place for the regulation of all healthcare providers by April 2024. The Trust is actively working to ensure internal systems and processes are in line with the new framework.

On an annual basis the Trust conducts a comprehensive review of compliance with all regulation and legislation, including CQC requirements. This process includes identifying any gaps in compliance, setting actions to address these and monitoring progress with achieving such actions and is led by the Executive team. The process also allows the Trust to understand and assure the robustness of its compliance with regulatory and legislative duties. The last review was presented to the Trust Board in March 2024.

The quality of performance information is primarily assessed by the Internal Audit programme. In 2023/24 this included review of Medicines Management and Chaperoning. Changes to systems and processes were made in line with subsequent recommendations. During 2022/23, a new health and safety legislation dashboard was introduced to provide greater oversight in this area. During 2023/24 this was subject to a review by Internal Audit which provided a reasonable assurance (positive) opinion.

On a monthly basis, the Trust Board consider the Integrated Performance Report which encompasses key metrics regarding quality, people and finances aligned with the NHS System Oversight Framework and the Trust strategic priorities. Board Committees are responsible for oversight of metrics within the remit of the Committee and the use of statistical process control charts and accompanying narrative facilitate this. The Quality & Clinical Governance Committee consider the quality metrics on a monthly basis and request deep dives into any areas of concern. People metrics are considered by the Strategic People Committee with the Finance & Business Performance Committee considering key performance metrics.

How risks to data security are managed and controlled

Risks to data security are managed in accordance with the NHS Information Governance classification framework and the Data Security and Protection Toolkit (DSPT) requirements.

Any gaps in controls are identified as risks and recorded, scored and reviewed in line with the Trust risk management policy. Additional oversight of cyber related risks is provided by the Cyber Information Security Officer (CISO).

Following a report of low compliance in 2022/23, in December 2022 the Trust was awarded 'Approaching Standards' status by NHS England. During 2023/24, ahead of the next submission in June 2024, significant steps have been made which build on the move of hosting support to Rackspace Private Cloud alongside work to upgrade network capacity and resilience. Compliance with the 113 standards of the DSPT is currently at 92%.

In June 2024 the Trust expects to be 'near compliance' with full compliance achieved by the end of the calendar year. The Trust have close working relationships with the other Chief Technical and Cyber Security Officers within the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS), and with the NHS England (NHSE) South-East regional cyber lead. This network shares best practice and regional assurance alongside the formal DSPT reporting requirements. The Trust has recently defended active cyber-attacks by suspected state actors and reassurance should be gained from this.

Major organisational risks

In 2021, the Trust published the BHT Strategy 2025 which set out three strategic priorities; outstanding care, healthy communities and great place to work and, alongside these, nine strategic objectives. The risks to achieving these objectives are set out within the Board Assurance Framework which was revised to align with the strategy in 2022. The principal risks facing the organisation, those with the potential to prevent the achievement of key objectives during the year 2023/24 were as follows:

Failure to provide care that consistently meets or exceeds performance and quality standards

This incorporates risk related to long elective waits, the provision of safe emergency, maternity and neonatal care and overall management of risk and clinical governance within the organisation. Key contributors comprise limitations of the estate infrastructure, including those related to infection prevention and control, data quality and digital immaturity, demand and capacity for services (including primary/social care capacity), increasing complexity of patients and service users and a lack of understanding and consistency in the application of clinical governance and risk management across the organisation.

Failure to deliver our annual financial plan

This reflects the underlying Trust organisational financial deficit, structural financial challenges including at system level, inflationary pressures and a mismatch in the demand and availability of capital funds.

Failure to work effectively and collaboratively with external partners

This risk reflects the Trust's ambitions as an anchor institution alongside some local uncertainty as structures and relationships within the local Integrated Care System develop and mature, recognising growth in this area during 2023/24.

Failure to provide consistent access to high quality care for Children and Young People

This reflects long waits for some community services alongside a significant increase in demand for such services, particularly related to educational needs, insufficient funding and an inability to recruit specialist staff. This is alongside limitations digitally and within the estate.

Failure to support improvements in local population health and a reduction in health inequalities

This risk reflects inequalities in access to care and the potential for continued growth in the health inequality gap. Digital immaturity and a failure to effectively utilise data to manage local population health is a key contributor.

Failure to deliver our People priorities

The five people priorities relate to recruitment and resourcing, culture and leadership, supporting our staff, workforce planning and development and productivity. Key contributors to this risk are identified as insufficient levels of appropriately skilled staff, national cost of living and resultant recent industrial action. Following the pandemic and subsequent sustained operational pressures, low morale is recognised as impacting negatively on colleague wellbeing and retention levels.

Failure to provide adequate buildings and facilities

This incorporates risk related to both estates and digital for which a lack of available capital is a significant contributor to both. The age of the estate and the lack of digital maturity are recognised as a standalone risk and also a key contributing factor in a number of other risks faced by the organisation.

Failure to learn, share good practice and continuously improve

This reflects some gaps in learning following incidents and the organisation not consistently being a place where new innovation and new ideas can be easily implemented.

The Board Assurance Framework, alongside the Corporate Risk Register, is considered by Trust Board and Board Committees as part of a regular report on overall organisational risk. The Board Assurance Framework provides details on strategic threats for each of the risks, potential effects should the risk materialise, existing controls and assurance records and subsequent gaps in assurance with mitigating actions. Overall review and moderation of risks as well as progress with mitigating actions are monitored by Board and Board Committees as well as through monthly meetings with Executive leads in line with the Trust Risk Management Policy.

CQC well-led framework

Following the inspection of medical and surgical services in February 2022, CQC conducted an inspection against the well-led framework in March 2022. The Trust was rated as ‘good’ for well-led which was an improvement on the previous rating (requires improvement).

The revised CQC single assessment framework incorporates eight ‘well-led’ quality statements and the Trust is currently undertaking a self-assessment against these.

Risks to compliance with the NHS provider licence

In May 2023 the Trust Board completed the required self-certification for 2022/23 that the Trust could meet relevant obligations set out in the NHS provider licence. These included;

- Effective systems to ensure compliance with considerations of the licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6)
- Compliance with governance arrangements (condition FT4)

In March 2023, a revised NHS provider licence was published which forms part of the oversight arrangements for all NHS providers. An assessment against this has been

undertaken for 2023/24 and will be presented to Board with the Trust demonstrating full or partial compliance for all provisions.

Following difficulties in appointing external auditors for 2022/23, and completion of the audit in line with a deferred timetable, the Trust has been successful in appointing auditors for the 2023/24 audit and work on this is underway.

The Directors Report provides further information on Board and Board Committee structures, roles and responsibilities.

The Trust remains in Segment 3 of the NHS Oversight Framework with an action plan in place to support movement to Segment 2.

Code of Governance for NHS Provider Trusts

A new code of governance for NHS providers came into force on 1 April 2023. Following an assessment of compliance against this, the Trust was non-compliant in two areas:

- The Senior Independent Director (SID) was also the Chair of the Audit Committee.
- The Trust did not have a formal policy in place for the purchase of non-audit services from external audit.

Action was taken to ensure compliance with both of the above. In July 2023, Nicola Gilham, Non-Executive Director, took over the role of Senior Independent Director and John Lisle, Non-Executive Director, become the Chair of Audit Committee. These roles were both previously held by Rajiv Jaitly, Non-Executive Director, who left the Trust on 14 June 2023 at the end of his term. In March 2023 the Audit Committee approved a policy regarding the management of non-audit work by the External Auditors.

Following both of these actions, the Trust is reporting full compliance against the code.

The key ways in which risk management is embedded in the activity of the organisation

As identified, the Trust Risk Management Policy sets out the processes by which risk is managed in the organisation. Alongside this, a range of supporting systems and processes are in place to embed risk management activity into the day-to-day activity of the Trust. These include:

- Through the Trust induction and mandatory training programme which includes information governance, safeguarding, fire safety, infection prevention and control, health and safety and manual handling.
- Incident reporting is openly encouraged across the Trust with promotion of just culture and appreciative inquiry. Lessons learned from incidents and investigations are shared and disseminated. More information on this can be found in Performance Review section of this Annual Report.
- The patient safety team has robust lines of communication with the Executive Directors, Director for Medical Education and the Freedom To Speak Up Guardian (FTSUG) to ensure that conditions where colleagues feel safe to report incidents are fostered and maintained.
- Risk is regularly discussed at a wide range of forums including the Trust Board and Committees and care group and service delivery unit (SDU) level governance meetings.
- Emergency preparedness systems are in place to ensure the Trust is able to respond, take action to control and mitigate risks at SDU, care group and organisational levels.

- Risk management is incorporated into the Trust planning and Cost Improvement Programme (CIP) through the Quality Impact Assessment (QIA) process.

The way in which the Trust ensures that workforce strategies and staffing systems are in place

The Trust complies with the NHS Developing Workforce Safeguards through a number of methods:

- A review of safe staffing levels is led by the Chief Nurse and this is presented to the Board on a quarterly basis. These reviews follow the National Quality Board guidance and cover three components: evidence-based tools, professional judgement and quality outcomes. In addition, supplementary papers are considered which focus on maternity and medical staffing.
- The Trust Board reviews all people metrics on a monthly basis as part of a wider review of quality, safety, performance and finance metrics to ensure that challenges and risks are understood as part of the wider context of service delivery. This is supported by daily staffing reviews, key governance meetings within the people directorate and the Strategic People Committee.
- The Trust has as annual workforce plan that is submitted centrally along with the annual financial and activity plans. The Trust Board discusses all of these plans prior to their submission.
- Where there are critical service risks related to staffing and the safe delivery of care, these are escalated to the Trust Board, and external regulators as required, along with associated mitigations. Information from relevant risk registers are utilised as part of this process.
- A workforce representative is present at all Silver Command meetings when the Trust command and control structure is stood up.
- Recognising the continued impact of COVID-19 on the physical health, mental health and wellbeing of our colleagues, the Trust continues the significant focus on its health and wellbeing offering. The Trust has enhanced the counselling resources available in the wellbeing service to support demand and enable more ‘outreach’ across the Trust to provide quick and easy access to all. The dedicated physiotherapy resource to support musculoskeletal health conditions has also been expanded.
- The NHS People Plan, including the People Promise, remains a key thread through the work of the Trust in supporting the strategic priority to be a ‘Great Place to Work’. In 2022, the Trust was selected as one of 23 exemplar sites for the NHS England People Promise Exemplar Programme.

The Trust has a range of mechanisms in place for colleagues to raise concerns which includes accessing the Freedom to Speak Up Guardian (FTSUG) services. During 2023, we have continued to embed our outreach model, which includes a lead Guardian, a number of part-time Guardians and Speaking Up champions (see below).

The Trust also has a Guardian of Safe Working Hours, as required in the 2016 junior doctor’s contract, who these colleagues can speak to in confidence. At Board level, dedicated Speaking Up Champion and Wellbeing Guardian roles are filled by Non-Executive Directors.

Care Quality Commission (CQC) registration

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

Fit and Proper Persons Regulation

The Fit and Proper Persons Regulation requires organisations to seek assurance that all directors are fit to undertake the responsibilities of their role and the Trust is held to account by the CQC in relation to this through Regulation 5. In August 2023, NHS England (NHSE) developed a new Fit and Proper Person test Framework. NHS organisations were expected to use the framework for all new board appointments and for annual assessments with the first annual submission required by 31 March 2024.

For the year 2023/24 each individual director completed their annual self-attestation. The submission template was presented to the Board in March 2024 ahead of submission to the Regional Director. This demonstrated full compliance.

Register of interests

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. www.buckshealthcare.nhs.uk/publications/reports-and-data/

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Obligations under equality, diversity and human rights legislation

A number of control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

- Cover sheets for all papers that are presented to the Executive Management Committee, all Board Committees and Trust Board include a section for the author to make Committee and Board members aware of any specific equality impact or implication.
- Executive and Non-Executive Directors have undertaken Allyship training and Executive Directors sponsor each of our staff networks.
- The Trust currently supports seven active colleague networks, more information on which can be found in the Performance Review section of this Annual Report:
    - BHT EMBRACE (BME colleagues).
    - BHT Disability (colleagues with long-term health conditions or disability).
    - BHT Belonging (LGBTQ+ colleagues).
    - BHT One in Four (supporting colleagues to talk about mental health).
    - BHT Women's Network
    - KALINGA (Filipino Healthcare Professional Organisation Bucks)
    - BHT Armed Forces Network
- Equality, diversity and inclusion training is provided to every new joiner to the Trust via the induction programme. Additional inclusion training is available via the internal 'Peaks' management and leadership development programme.
- All Trust policies and relevant business cases include an equality impact assessment.

The Trust's Public Sector Equality Duty (PSED) report has been published and is available on the Trust website. https://www.buckshealthcare.nhs.uk/publications/equality-and-diversity-reports/

A number of control measures are in place to ensure the Trust meets and complies with all relevant obligations including:

- All Trust policies have an integral compliance and monitoring section with annual monitoring requirements.
- Monthly review of workforce related data by the HR and Workforce Group.
- Employee Relations Tracker for ongoing monitoring of cases with annual overview of this through PSED, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reporting.
- Annual review of the Trust equality, diversity and inclusion objectives.
- At least an annual review of WRES and WDES reports by Trust Board and at a Divisional level.
- Completion of equality impact assessments as per above.

Obligations under the Climate Change Act and the Adaption Reporting requirements

The Trust has undertaken risk assessments, has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme and ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. To progress towards the NHS ambition to become carbon net zero by 2024, the Trust published its Net Zero Roadmap in 2021. An annual audit of progress against this plan is undertaken annually.

Review of economy, efficiency and effectiveness of use of resources

The Trust is required to demonstrate that it achieves value for money for taxpayers by demonstrating economy, efficiency and effectiveness in the use of resources available. The Trust's governance processes provide assurance regarding use of resources with regular scrutiny by the Capital Management Group, Executive Management Committee, Finance & Business Performance Committee, Audit Committee and Trust Board. The executive-level Transformation Board provides assurance that transformation plans are delivered successfully and associate benefits relating to quality, people and money are realised. Governance for divisional performance is through monthly review meetings.

In 2023/24 the Group delivered a £5.6m deficit against its statutory reporting position; £6.1m being the deficit forecast reported to NHS England. Related to capital, the Group reported a £58.6m expenditure against its allocation of £58.6m for 2023/24.

The 2024/25 budget has been proposed with a full year deficit plan of £28.0m and a capital plan of £27.7m. The budget includes significant efficiencies of £36.0m, equivalent to 6%. At the time of writing, plans for 2024/25 have not been finalised.

External auditors are required to provide an opinion on whether they are satisfied that, in all significant respects, the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness for its use of resources for the year ending 31 March 2023. External auditors have been appointed and the audit is underway.

The draft Head of Internal Audit Opinion for 2023/24 is that the organisation has an adequate and effective framework for risk management, governance and internal control. However, further enhancements to the framework have been identified to ensure that it remains adequate and effective. During the year one report were presented with minimal assurance (negative). Two reports were issued with a partial assurance opinion (negative), seven with a reasonable assurance opinion (positive) and one with a substantial assurance opinion (positive). The details of all reports are considered by the Audit Committee who also monitor the implementation of actions to address identified weaknesses. The Executive Management Committee collectively considered all reports with a negative opinion and

maintained a strong focus on supporting the implementation of management actions throughout the year.

During 2023/24, the Trust continued to use the Healthcare Financial Management Association (HFMA) financial sustainability self-assessment tool to support rigour in processes related to financial sustainability.

Information governance

Any serious incidents that meet the required threshold are reported to the Information Commissioner's Office via the Data Security and Protection Toolkit.

For the period 2023/24 there were two serious incidents which were notified to the Information Commissioner's Office (ICO). These related to inappropriate access to a patient record and the use of Facebook/Meta Pixel on the Trust website. The incident relating to inappropriate access to a patient record resulted in an Information Commissioner's Office decision that as the matter was being managed through internal HR processes in conjunction with Thames Valley Police, no further action was required from them at that time. Regarding the use of Facebook/Meta Pixel on the Trust website, the Information Commissioner's Office considered the remedial actions taken by the Trust and a decision was made not to take any enforcement action.

Data quality and governance

A number of measures are in place to assure the quality and accuracy of data, including that which relates to elective waiting lists:

- The Trust has an Elective Care Access Policy which encompasses a number of Standard Operating Procedures for waiting list management at all stages of a referral to treatment pathway. The policy outlines the responsibilities of key colleagues including those related to the auditing of data quality.
- The Trust also has a Data Quality Policy which supports the principles of the information governance agenda in the element of quality assurance and as produced to achieve and maintain high quality data throughout the Trust. The policy describes the approach to data quality and outlines the role and responsibilities of the Data Quality Group.
- A weekly validation process is in place involving operational, management and information leads to assure the quality of local and national waiting times including the Referral to Treatment (RTT) pathway and ensure this information is both up to date and correct.
- A regular checking process is in place for RTT patients who have been removed from the waiting list following a non-patient interaction/validation. This is to assure data quality but also identify opportunities for improvement and/or training that support continued implementation and alignment with the Elective Care Access Policy.
- Within cancer services, patient level information is reviewed daily as part of multidisciplinary team meetings and tracing processes to support patient pathway management.

Data quality is also assessed through the Internal Audit programme. In 2023/24, a specific audit was undertaken into data quality across the organisation and changes to systems and processes were made in line with subsequent recommendations.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within Buckinghamshire Healthcare NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee and the Quality & Clinical Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The draft Head of Internal Audit Opinion for 2023/24 states that "the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective". The last sentence of the opinion reflects that 1 report received a minimal assurance opinion (Management of IT Assets), 2 reports received a partial assurance opinion (Chaperoning Policy and Data Quality) and 7 received a reasonable assurance opinion (UK Visas and Preparation for Renewal of Tier 2 Licence, Overseas Patient Income, Medicines Management, CQC Action Plan, Health & Safety Legislation Assurance Processes, Temporary Staffing and Agency Spend and Financial Management). One report received a substantial assurance opinion (Mandatory Training). The Audit Committee approves the Internal Audit annual plan for work and receives reports from each of the reviews undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the Executive Management Committee during the year.

Significant internal control issues

Four Never Events were reported by the Trust in 2023/24:

a) The unintentional connection of a patient requiring oxygen to an air flowmeter.
b) Wrong site surgery – anaesthetic placed at an incorrect site.
c) Wrong site surgery – botox injected into an incorrect muscle.
d) Wrong implant/prosthesis – incorrect prosthesis used during surgery.

All incidents have been investigated, reports for which were approved by the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB). Incident (a) was cross checked to a similar historical incident in order to review the robustness of existing safety recommendations. All resultant actions have been completed.

As a result of the remaining incidents, the Trust Safer Surgery Policy has been reviewed and amended and work is ongoing to standardise safety checklists for invasive procedures across the Trust.

Conclusion

The significant internal control issues which have been identified during 2023/24 are described above, namely four Never Events and two information governance related serious incidents reported to the Information Commissioner's Office.

Signed……

Chief Executive Date

Modern Slavery Act 2015

The Modern Slavery Act 2015 establishes a duty for commercial organisations with an annual turnover in excess of £36 million to prepare an annual slavery and human trafficking statement. This is a statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business.

A statement regarding slavery and human trafficking was published on the Trust website in July 2023 and is due for review in July 2024.
www.buckshealthcare.nhs.uk/documents/modern-slavery-declaration/

Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed……..

Chief Executive Date: XX

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

Date: 29 May 2024

Agenda item	Approval and signature of NHS Education Funding Agreement 2024-27
Board Lead	Bridget O'Kelly, Chief People Officer
Author	Jan Marote, Assistant Director of Clinical Education
Appendices	NHSE Education Funding Agreement 2024-27 is provided as a separate document
Purpose	Approval
Previously considered	EMC 21.05.2024

Executive summary

The 2024-27 NHS Education Funding Agreement will replace the current 2021-24 NHS Education Contract which ended on 31 March 2024.
The Trust will be required to sign a new three-year NHS Education Funding Agreement in order to receive our educational funding.

The agreement is the formal mechanism for the relationship between NHSE and providers of education and training. It covers both education and placement providers. It governs the use of future workforce funding (including, but not limited to, placement tariff, salary support and where appropriate unless commissioned separately tuition funds) passed to education and training providers which supports the education and training of learners targeted via this agreement.

The value of this agreement is expected to be similar to last year (£13,279,826), with some reductions expected due to the national NHS funding pressures. Funding is allocated nationally, in-line with the Department of Health and Social Care Education and Training Tariff Guidance and the NHS Education Funding Guidance, which are both updated annually. There is no opportunity for providers to influence the allocation.

The new NHS Education Funding Agreement 2024-27 has no material changes within it and is effectively shifting the relationship from HEE to NHSE.

The new agreement strengthens the wording around how these monies can be used:

- Section 16 of the new agreement stipulates financial transparency in the use of educational funding, and that the funding supports collective efforts to provide the highest quality healthcare education and training and is not assigned to any other services.

- Section 17 of the new agreement states that funding is not assigned to education and training the Trust may be required to repay all or part of the funding

- The Trust is required to sign the new three-year NHS Education Funding Agreement in order to receive our educational funding. This approval will be sought via an electronic DocuSign link which will be sent to the Trust by NHSE.

The Executive Management Committee considered the agreement on 21 May 2024 and recommended for approval. A verbal update of the discussion at Finance & Business Performance Committee.

Decision	The Board is requested to approve the agreement.

Relevant strategic priority			
Outstanding Care ☐	Healthy Communities ☐	Great Place to Work ☒	Net Zero ☐

Relevant objective		
☐ Improve waiting times in ED ☐ Improve elective waiting times ☒ Improve safety through clinical accreditation	☐ Give children living in most deprived communities the best start in life ☐ Outpatient blood pressure checks	☐ Zero tolerance to bullying

Implications / Impact	
Patient Safety	Education is key to our staff in maintaining and safe clinical practice
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 6: Failure to deliver our People priorities Related to recruitment and resourcing, culture, and leadership, supporting our staff, workforce planning and development and productivity
Financial	Education funding is provided by NHSE in the form of student tariff, CPD, salary support. We are required to sign the Education Funding Agreement so that NHSE can release education funding to the Trust. Our financial risk is that without the agreement we would not receive funding and would not be able to deliver CPD, train staff groups that are salary supported and support healthcare students who are our future workforce pipeline.
Compliance CQC Standards Safety	Clinical staff require appropriate and adequate education to provide safe and effective patient care.
Partnership: consultation / communication	NHSE reporting processes – we have to provide assurance on various NHSE returns that the funding is being utilised for training and education
Equality	Education is key enabler of development and at BHT we have a track record of supporting a higher proportion of BAME colleagues in accessing non mandatory education. Our programmes are all designed to be as accessible as possible via use of online, read aloud, enlargeable text and fonts and handbooks. Education programmes are audited regularly by commissioners for quality and inclusion. We are also linked in with our staff networks to ensure we can get direct feedback and respond rapidly to any/all educational needs of all of our people. Education venues are also made available to all colleagues for celebration of cultural and diverse events.

	Equality in the allocation of funding for Continued Professional Development is included in the annual WRES Data Report.
Quality Impact Assessment [QIA] completion required?	N/A

Background
The 2024-27 NHS Education Funding Agreement will replace the current 2021-24 NHS Education Contract which ended on 31 March 2024. This will govern the use of future workforce funding (including, but not limited to, placement tariff, salary support and where appropriate unless commissioned separately tuition funds) passed to education and training providers which supports the education and training of learners targeted via this agreement.

The value of this agreement is expected to be same as last year (£13,279,826), with some reductions expected due to the national NHS funding pressures Funding is allocated nationally, in-line with the Department of Health and Social Care Education and Training Tariff Guidance and the NHS Education Funding Guidance, which are both updated annually. There is no opportunity for providers to influence the allocation.

Purpose of the New NHS Education Funding Agreement
The new agreement retains the same purpose as its predecessor NHS Education Contract which are as follows:

- To allow NHS England to financially support training and education through payment of a range of supporting monies including, but not limited to, salary support for employed learners, tariff for healthcare placements, and training grants.
- To achieve a nationwide consistent approach to contracting and funding for education and training.
- To make it easier to understand how public funds are used, and to outline the return-on investment expectations for the funding used in training the healthcare workforce.
- To better accommodate non-NHS education and training partners in training delivery, to encourage a wider selection of training partners to improve training capacity, quality, and student experience.
- To become a key tool for improving the quality of education and training, driving change, and providing funding.

BHT Engagement
Engagement activities have been undertaken by NHSE and the Trust has had an opportunity to provide feedback and ask questions about the new agreement. These activities included:

- Pre-consultation engagement webinars to inform the development of the draft 2024-27 NHS Education Funding Agreement in Autumn 2023.
- A stakeholder review of the draft NHS Education Funding Agreement to capture feedback on any of the proposals. We are currently awaiting NHS England the final versions of the generic Agreement.

Proposed Changes to the Contract
The material changes and updates to the content of the NHS Education Funding Agreement 2024-27 by NHSE are summarised below. These changes have no impact on the Trust as our current delivery and governance structures and processes are able to deliver these.

4.1. Core Terms
The core terms section applies to all providers. It sets out how the parties to the agreement will manage the relationship to be enacted via this agreement.
The section has been updated to reflect how NHS England wishes to govern education and training services enacted via this agreement.

4.2. Schedule 1 – Provider Services
The schedule sets out the services targeted at providers under the agreement.
The section has been updated to reflect how NHS England wishes to govern education and training services enacted via this agreement.

4.3. Schedule 2 – Funding
This schedule deals with finances and sets out how funding will be managed via this agreement.
The schedule has been updated and funding will be specified when services are agreed between parties.

4.4. Schedule 3 – Quality & Contract Performance Management
The section sets out NHS England's baseline expectations regarding the Quality and Contract performance to be maintained by providers throughout the term of this agreement.
The section has been updated to reflect how NHS England wishes to govern key performance indicators that must be adhered to via this agreement.

4.5.1 Schedule 4 A – Undergraduate Dental Education Tri-partite Agreement (UGDE TPA)
This is a new section introduced to govern UGDE activity served via this agreement, which also identifies the funding for this activity as set out in the DSHC Education and Tariff Guidance published annually.
This section applies solely to NHS England, Education Providers and Placement Providers that support UGDE.
Parties targeted for UGDE activity will be agreeing to the terms set out in the agreement by signing the NHS Education Funding Agreement.
Additionally, a Letter of Coordination will be the mechanism to enact the TPA and must be signed by all parties to be eligible for funding targeted under this section.

4.5.2 Schedule 4 B Undergraduate Medical Education Tri-partite Agreement (UGME TPA)
The section governs UGME activity served via this agreement, which also identifies the funding for this activity as set out in the DSHC Education and Tariff Guidance published annually.
This section applies solely to NHS England, Education Providers and Placement Providers that support UGME.
Parties receiving funding for UGME services will be agreeing to the terms set out in the agreement by signing the NHS Education Funding Agreement.
Additionally, a Letter of Coordination will be the mechanism to enact the TPA and must be signed by all parties to be eligible for funding targeted under this section.

4.6. Schedule 5 – Data Sharing Model Agreement
The old Schedule 5 – Processing, Personal Data and Data Subject Template has been removed from the new agreement. The new agreement Schedule 5 will contain the Data Sharing Agreement which was previously Schedule 6.
The new section sets out standard Data Sharing Agreement to be enacted between the parties via this agreement.
The sections have been updated to reflect how NHS England wishes to manage data collated in relation the NHS Education Funding agreement.

4.7 Schedule 6 – Change Control Notice Template
The old Schedule 6 Data Sharing Agreement to be replaced as Change Control Notice Template Form (CCN).
The new schedule is replacing the Annexes from schedule 1, 4 and 6 in the current contract and separate as Schedule 6.
This schedule has been introduced to replace the multiple CCN annexes in the old contract.

This schedule will be used when a material change is to be introduced, additions to services, new terms or funding needs to be set out after the agreement has been signed by parties.

4.8 Schedule 7 – Secondment Agreement
Schedule 7 has been introduced as a Secondment Agreement. It has been relocated as an Annex from Schedule 1 as a separate Schedule.
The schedule relates solely to Education Support activity set out in Schedule 1 – Provider services, section 14.1.3. Secondment Agreement.

Next steps
EMC is asked to note this change and recommend to the Board that the agreement be signed when it is received.

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

Date: 29 May 2024

Agenda item	Maternity Quarterly Quality Report Q4 23/24
Board Lead	Karen Bonner Chief Nurse
Author	Michelle East Director of Midwifery
Appendices	Appendix 1 Q4 PQSM report Appendix 2 Q4 ATAIN audit Appendix 3 Q4 claims scorecard Appendix 4 Q4 improvement highlight report *Appendices all available in the Reading Room*
Purpose	Assurance
Previously considered	EMC 07.05.2024 QCGC 15.05.2024

Executive summary

This report provides an overview of current maternity quality issues focusing on the following work streams:

- Perinatal mortality and morbidity relating to both woman and fetus/baby
- Themes relating to litigation, complaints and serious incidents
- Performance related to external assurance
- Indicator of staff culture and service user feedback

In Q4 there were a total of five stillbirths and one neonatal death. One of these cases has met the criteria for referral to MNSI, two had an after-action review, all deaths will be reviewed via the perinatal mortality review tool (PMRT) in the required timeframes. There were no maternal deaths and one ITU admission. There were no emergency hysterectomies.

Perinatal mortality data published for 2022 showed an improvement on the previous two years in both crude and stabilised and adjusted data.

MNSI published a review of all cases referred from BOB Local Maternity and Neonatal System. BHT had the lowest number of referrals. Key themes were explored and demonstrated a year-on-year reduction in referrals relating to inappropriate analysis of fetal monitoring.

Smoking at time of birth is showing a special cause variation of an improving nature and is performing well, consistently below national target of 6% and more recently below the locally set ambition of 5%. Smoking cessation engagement is also showing special cause variation of an improving nature.

Term admission rates to the neonatal unit remain within common cause variation and are below target in March.

NHS Resolution have confirmed that all 10 safety actions of the maternity incentive scheme have been achieved. Final details regarding income from this to be confirmed in May.

The Perinatal Culture and Leadership programme has now concluded, and the SCORE now closed. Korn Ferry will be leading feedback of data from this survey and supporting the development of appropriate actions.

Public engagement around Wycombe Birth Centre re-design now complete, with a report due to the Health and Adult Social Care committee in July.

The Executive Management Committee considered the paper on 7 May 2024 and the Committee requested an increase in reporting around the culture across both midwifery and medical staff groups to ensure this was effectively reflected as part of the oversight of quality and safety.

On 15 May 2024, the Quality & Clinical Governance Committee considered the paper and discussed changes in the management/investigation of incidents under the new Patient Safety Incident Response Framework (PSIRF).

Decision	The Board is requested to discuss and take assurance

Relevant strategic priority			
Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☐

Relevant objective		
☐ Improve waiting times in ED ☐ Improve elective waiting times ☐ Improve safety through clinical accreditation	☒ Give children living in most deprived communities the best start in life ☐ Outpatient blood pressure checks	☐ Zero tolerance to bullying

Implications / Impact	
Patient Safety	This paper provides updates on patient safety and maternity quality improvement work streams, issues and any risks to compliance.
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 1: Failure to provide care that consistently meets or exceeds performance and quality standards CRR 287 – Midwifery staffing
Financial	NHSR Maternity Incentive Scheme: Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.
Compliance CQC Standards Safety	Safety Person centred care Duty of candour Good governance Complaints
Partnership: consultation / communication	Acute paediatrics- neonatal services Local Maternity and Neonatal System Maternity voices partnership Maternity and neonatal safety champions
Equality	It is essential to have an increased focus on reducing health inequalities for Black, Asian and minority ethnic women and women who are affected by social deprivation. Maternal mortality is 3.7 times greater for Black women and 2 times greater for Asian and mixed ethnicity women than white women (MBRRACE 2022).

	Perinatal mortality is greater for Black and Asian babies- the highest rates of stillbirth affect Black African and Black Caribbean babies from the most deprived areas; the highest rates of neonatal death affect Pakistani and Black African babies from the most deprived areas (MBRRACE 2022).
Quality Impact Assessment [QIA] completion required?	No

Glossary and Abbreviations

ATAIN	A patient safety programme (an acronym for '**avoiding term admissions into neonatal units**') to reduce avoidable causes of harm that can lead to infants born at term (i.e., ≥ 37+0 weeks gestation) being admitted to a neonatal unit.
BOB LMNS	Buckinghamshire, Oxfordshire and Berkshire West local maternity and neonatal system - a partnership of maternity and neonatal service providers, commissioners, local authorities and maternity and neonatal voices partnerships, who are working together to transform maternity services
CQC	Care Quality Commission
MIS	Maternity Incentive Scheme - The scheme supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST.
MNVP	Maternity and Neonatal Voices Partnership - is a NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care
NHSE	NHS England – leads the national health service for England
NHSR	NHS Resolution- the operating name of NHS litigation authority, is an arm's length body of the department of Health and Social Care
NNU	Neonatal Unit
PCSP	Personalised care and support plan – a holistic person centred process that enables the person to identify their needs and outcomes
PMRT	Perinatal Mortality Review Tool
PQSM	Perinatal Quality Surveillance Model – a framework for increasing oversight of perinatal clinical quality in the NHS, England
RCOG	Royal College of Obstetrics and Gynaecology
SBAR	A communication tool to convey critical information requiring immediate action and advice
VTE	Venous thromboembolism

1 Introduction/Position

This report provides an overview of current maternity quality issues in line with NHS England (NHSE) guidance on perinatal quality surveillance and NHS Resolution (NHSR) maternity incentive scheme standards. This report will highlight performance against the key drivers to deliver and maintain a safe, high quality maternity service and will focus on the following workstreams:

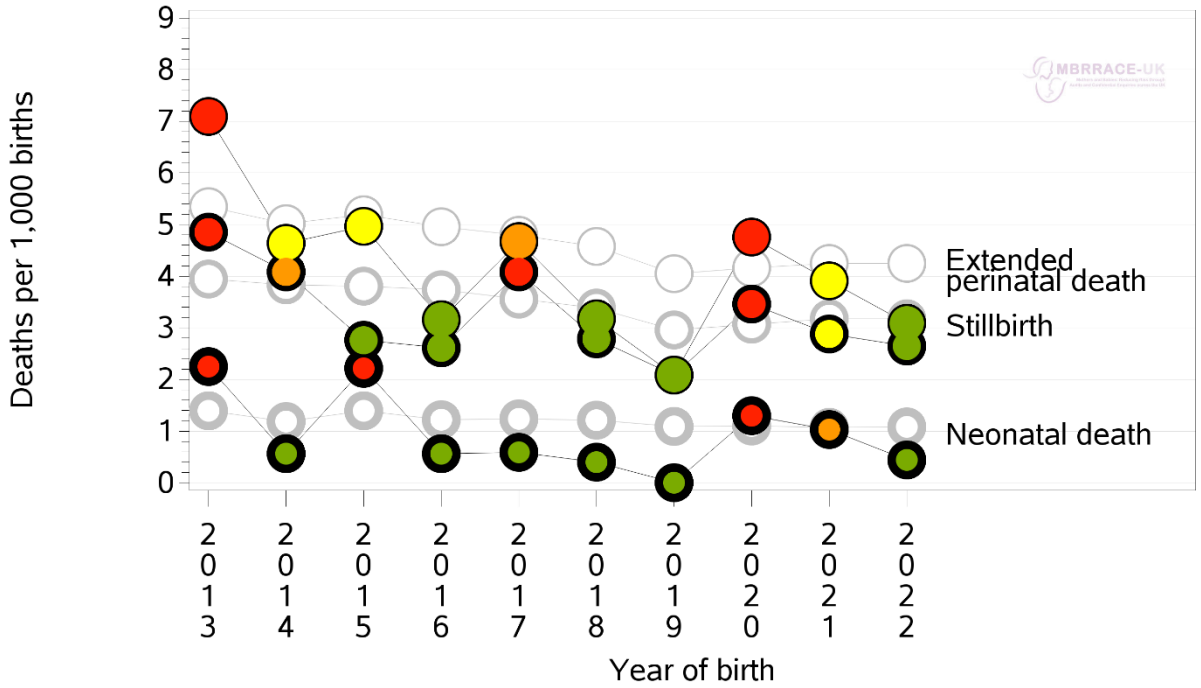
- Perinatal mortality and morbidity relating to both woman and fetus/baby
- Themes relating to litigation, complaints and serious incidents
- Performance related to external assurance
- Indicator of staff culture and service user feedback

2 Perinatal Mortality and Morbidity

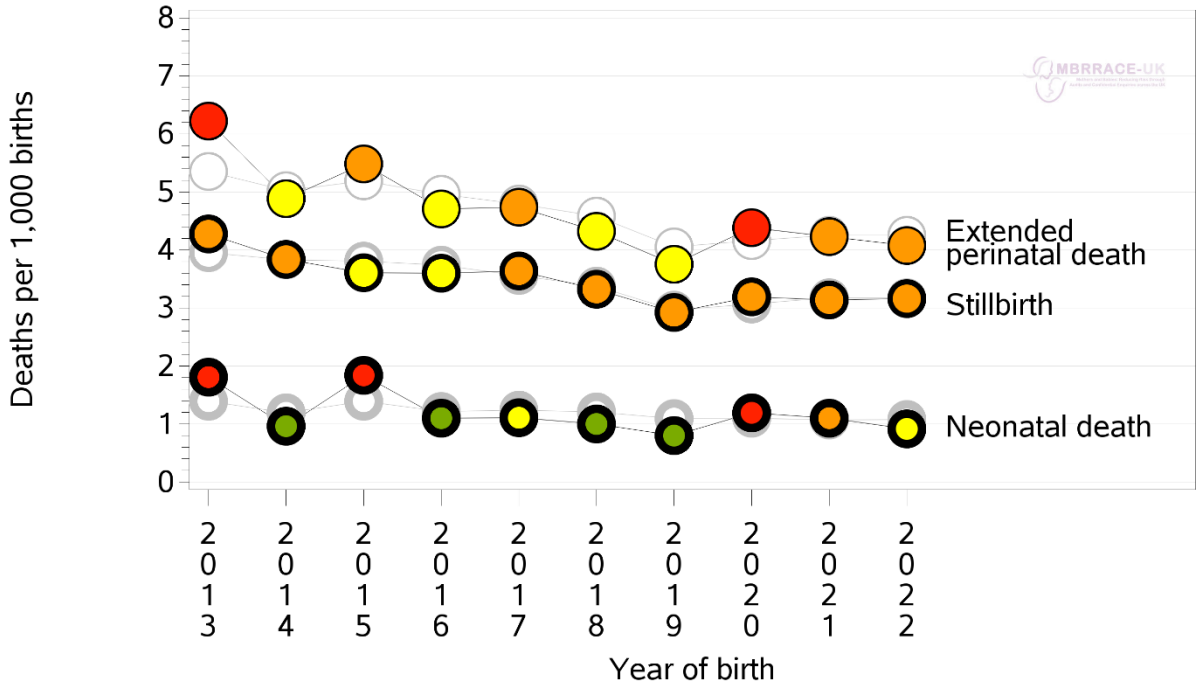
The BOB local maternity and neonatal system (BOB LMNS) have a defined perinatal quality surveillance reporting model to ensure a standardised reporting process.

Buckinghamshire Healthcare NHS Trust (BHT) perinatal quality surveillance data for this reporting period is detailed in full in Appendix 1. Crude and stabilised and adjusted data for 2022 was published in March. The data below demonstrates improvement across all categories.

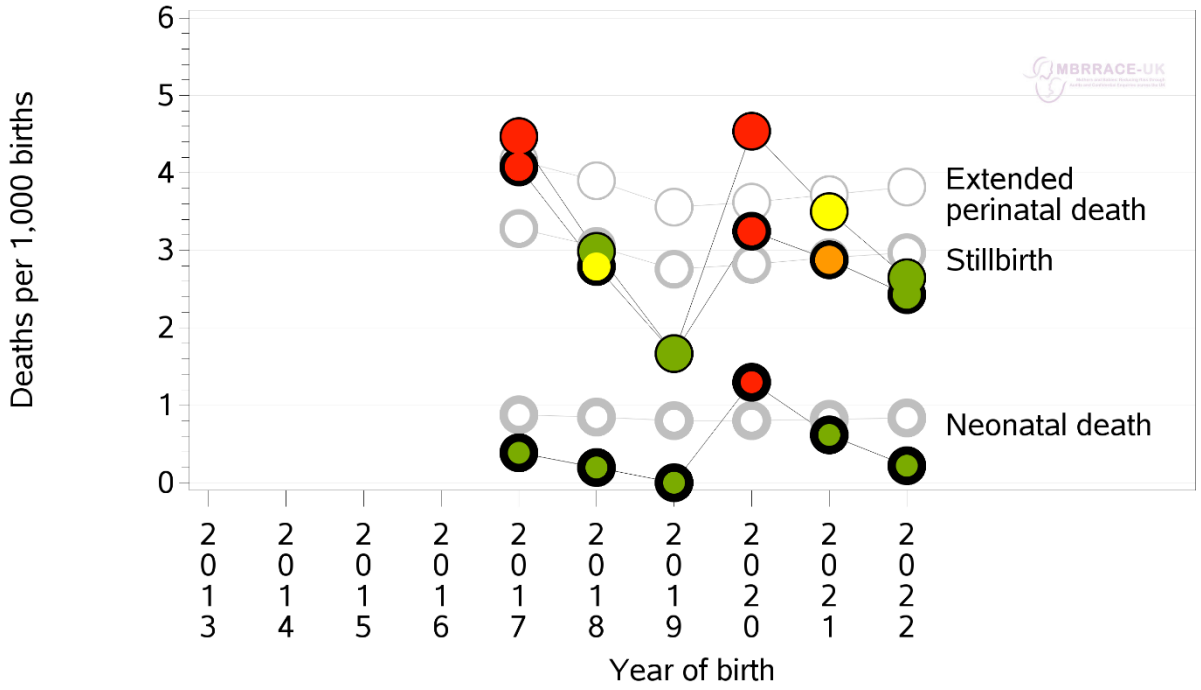
Crude mortality rates for babies born at 24 weeks gestational age or later by year of birth



Stabilised & adjusted mortality rates for babies born at 24 weeks gestational age or later by year of birth



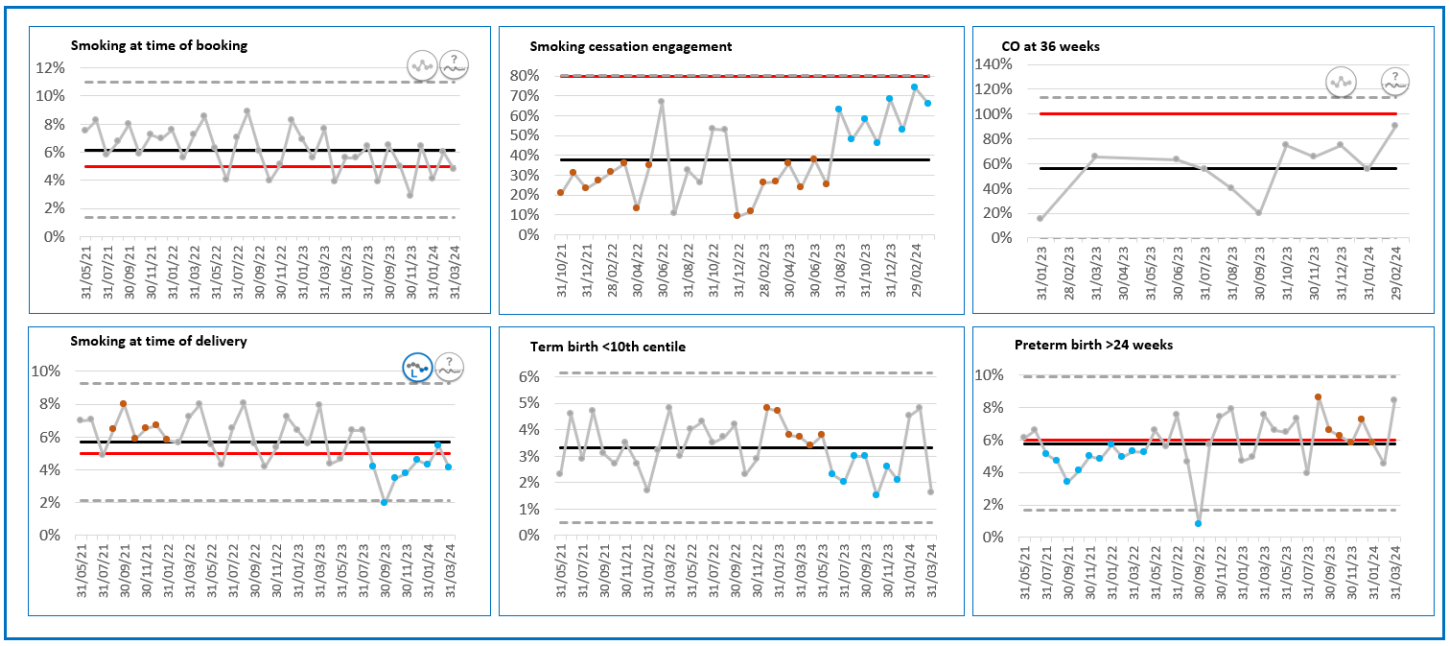
Crude mortality rates for babies born at 24 weeks gestational age or later by year of birth: excluding deaths due to congenital anomalies



2.1 Fetal/neonatal mortality and morbidity

Indicators for possible fetal or neonatal loss include smoking, ethnicity, deprivation, and risks associated with intrauterine growth restriction (IUGR) and/or preterm birth.

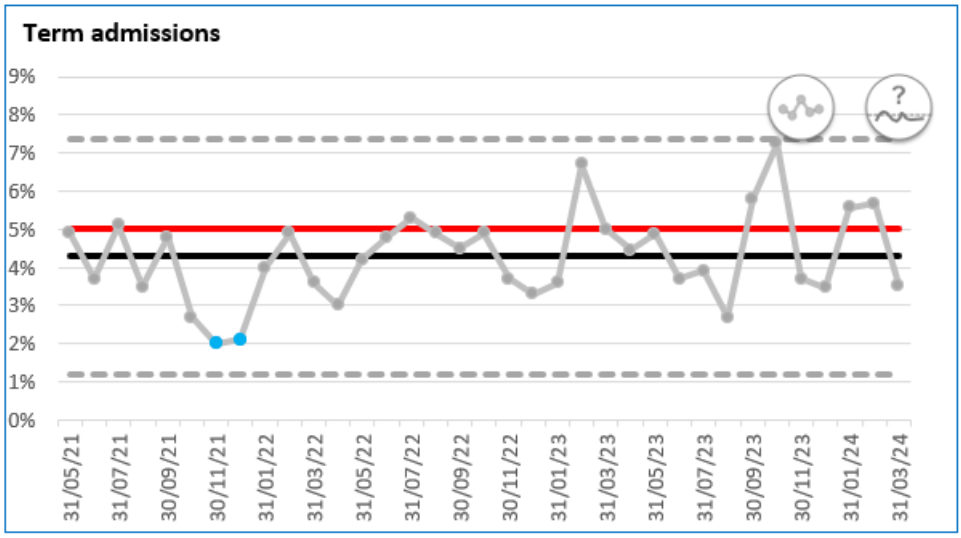
During Q4 overall rates of smoking at time of booking are 5%, smoking at time of delivery is 4.3%.



Of the women who experienced a fetal loss during this quarter:

- One was a smoker with a slightly elevated CO at booking
- One was Black African
- Two lived in areas of higher deprivation

The ATAIN programme continues to be embedded in practice through the annual ATAIN action plan.

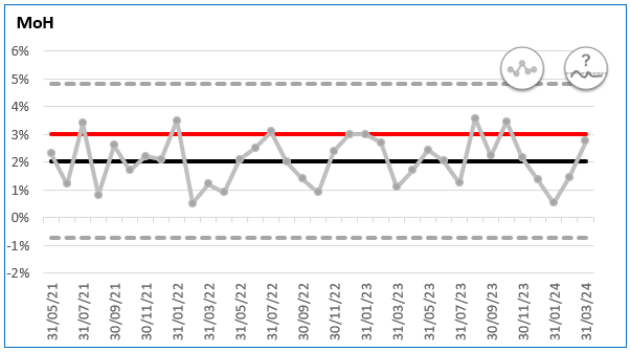


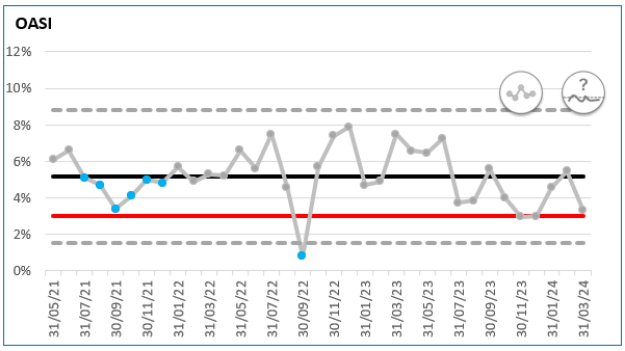
Respiratory remains the primary reason for admission (57%, this is a decrease from last quarter which was 63%). Of the 31 babies admitted, 26 required respiratory support via high flow oxygen therapy and eight were managed with supplementary oxygen therapy via nasal cannula. Although no themes could be identified it was noted that 68% of these cases were delivered by caesarean section. Caesarean section is known to be associated with an increased rate of neonatal morbidity (RCOG Planned Caesarean Birth (consent advice) 2022).

2.2 Maternal mortality and morbidity

Indicators for possible maternal mortality or morbidity include venous thromboembolism, massive haemorrhage, obstetric anal sphincter injury and eclampsia. During Q4 all women were risk assessed for pre-eclampsia and VTE. There were no hospital acquired VTE and no cases of eclampsia.

	No of days since
Eclampsia	No cases in past 3 years
ITU admission	51
Hysterectomy	309





The haemorrhage rate remains stable within common cause variation and below target for the majority of months. The OASI rate for Q4 rate remains above target. We have the highest rate of this incident in BOB. Whilst this is a focus in the mandatory training for midwives and doctors this year, collaboration with our peers across the system may support improved performance around this metric.

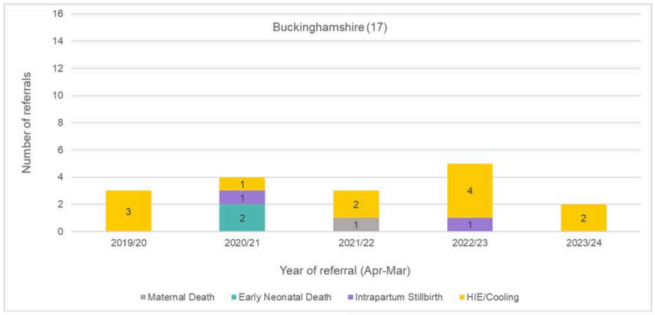
3 Themes relating to litigation, complaints and serious incidents

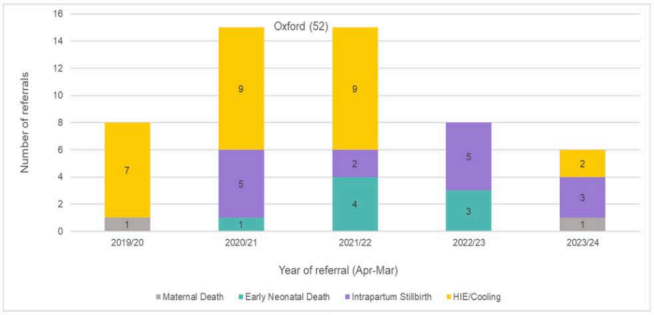
Themes from litigiation cases are triangulated with complaints and serious incidents and are reflected in Appendix 3. These themes are driving improvement in multiple internal processes across maternity and neonates.

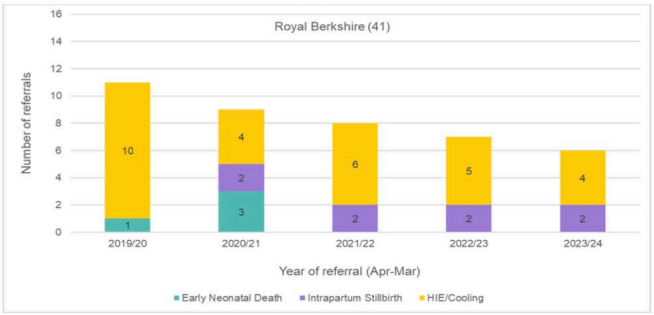
All referrals to MNSI were reviewed across BOB, the following charts demonstrate that BHT have the lowest number of qualifying incidents across the LMNS. All maternity services in the system have engaged in a move to physiological interpretation of electronic fetal heart rate monitoring. This resulted in unified guidance, tools and training across the system. Clinical safety is improving as a result of this as can be seen in the eradication of fetal monitoring related incidents being referred to MNSI across the system and a local reduction in the number of babies being born with abnormal umbilical cord gases.

Maternity investigations - Trust

110 progressed to investigation broken down by the 3 Trusts.







LMNS top recommendations*

97 completed reports.
29 reports *did not have* recommendations against the primary provider.
68 reports *did have* recommendations against the primary provider.

2019/20
- Fetal Monitoring
- Clinical Assessment
- Guidance

- 1 reports with no recommendations
- 8 reports with recommendations

2020/21
- Guidance
- Fetal Monitoring
- Clinical Oversight
- Clinical Assessment
- Escalation

- 6 reports with no recommendations
- 19 reports with recommendations

2021/22
- Clinical Assessment
- Guidance
- Fetal Monitoring
- Clinical Oversight
- Communication

- 5 reports with no recommendations
- 23 reports with recommendations

2022/23
- Clinical Assessment
- Guidance
- Risk Assessment
- Fetal Monitoring

- 11 reports with no recommendations
- 13 reports with recommendations

2023/24**
- Clinical Assessment
- Guidance
- Risk Assessment
- Ultrasound Scans
- Communication

- 6 report with no recommendations
- 5 reports with recommendations

*Based on the year of report publication. The number of top recommendations may vary depending on their frequency.
**2023/24 is not yet a full financial year (Apr-Mar).

4 Performance related to external assurance

Maternity Incentive Scheme

NHS Resolution have confirmed compliance with all ten safety actions of the 2023 scheme. The 2024 scheme is now available and work will commence to embed any changes to last year's scheme.

Single Delivery Plan Progress

Theme/objective	Progress	A	B	C	D	E	F
Listening to and working with women	Objective 1						
	Objective 2						
	Objective 3						
Growing, retaining and supporting our workforce	Objective 4						
	Objective 5						
	Objective 6						
Developing and sustaining a safety culture	Objective 7						
	Objective 8						
	Objective 9						
Standards and structures to underpin safe, equitable care	Objective 10						
	Objective 11						
	Objective 12						

5 Culture

The SCORE survey of staff across the maternity and neonatal services has now closed. Feedback and analysis of results is being facilitated by Korn Ferry who will also be working with the team to develop appropriate actions. The MDT participated in a workshop to develop initiatives to improve retention of staff. The maternity team will now work with The maternity team will now work with OD, HR and the wellbeing team to develop a local improvement plan.

5.1 Responding to feedback from staff and service users

Monthly speak up sessions scheduled for colleagues within maternity to join. The current session raised the following issues:

- Widening attendance at the morning maternity and neonatal safety huddle

- Expanding the use of Careflow Connect to the day assessment unit

Solutions to these challenges are being implemented. In response to service user feedback, overnight stays for partners on Rothschild Ward have been re-introduced. 15 steps with the MNVP have taken place across all areas of the maternity service in Q4, there were a small number of suggestions to improve the environment considered, however no significant issues or concerns were raised by the service users in attendance.

Extensive service user feedback has been gained relating to the services available on the Wycombe Birth Centre site. These have been collated and will be reported to the HASC in July.

6 Improvement initiatives

The initial data from the triage rapid improvement project follow-up has now been collated. This demonstrates an improvement in time to initial risk assessment and initial midwifery review. Monthly meetings continue in order to ensure momentum is not lost on this important project and to ensure that changes are sustained.

The maternity EPR project is now underway with a planned go live of February 2025. This is providing an opportunity to review processes to improve efficiency, safety and quality. In response to this the first draft of a five-year maternity transformation programme is due to be presented to Transformation Board in May 2024.

The enclosed Improvement highlight report (Appendix 4) outlines other key improvements implemented or in progress during the quarter, along with key risks.

8 Action required from the Board/Committee

The Board is requested to:

a) Discuss and take assurance

APPENDICES

Appendix 1 Q4 PQSM report
Appendix 2 Q4 ATAIN audit
Appendix 3 Q4 claims scorecard
Appendix 4 Q4 Improvement highlight report

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

Date: 29 May 2024

Agenda item	Midwifery Staffing Six Monthly Oversight Report Oct 23-April 24
Board Lead	Karen Bonner Chief Nurse
Author	Michelle East Director of Midwifery
Appendices	None
Purpose	Assurance
Previously considered	EMC 07.05.2024 Q&CGC 15.05.2024

Executive summary

This is the first 6-monthly staffing report of 2023/24 which reviews safe staffing levels for Maternity Services. The aim of this report is to provide assurance of an effective system of workforce planning

The report provides assurance that:

- A systematic, evidence-based process to calculate midwifery staffing establishment been completed
- The Trust Board supports a midwifery staffing budget to reflect establishment as calculated in BirthRate+
- Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.
- The midwife to birth ratio is monitored
- The team of specialist midwives employed provides mitigation to cover any inconsistencies. (BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives)
- The midwifery coordinator in charge of labour ward maintains supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
- All women in active labour received one-to-one midwifery care
- A midwifery staffing oversight report is produced that covers staffing/safety issues to the Board at least every 6 months during the maternity incentive scheme year five reporting period.

The information presented in this paper demonstrates that despite significant challenges within the maternity workforce, appropriate short and long term mitigation is in place which provides assurance that BHT has an effective system of midwifery workforce planning and monitoring of safe staffing levels with the appropriate escalation plans in place.

The Executive Management Committee considered this paper on 7 May 2024 and requested future reports demonstrated the current position against planned recruitment activity to provider greater assurance.

The paper was further considered by the Quality and Clinical Governance Committee on 15 May 2024 who took assurance from the report following a detailed discussion on unavailability rates.

Decision	The Board is requested to discuss and take assurance

Relevant strategic priority

Outstanding Care ☒	Healthy Communities ☐	Great Place to Work ☒	Net Zero ☐

Relevant objective

☐ Improve waiting times in ED ☐ Improve elective waiting times ☐ Improve safety through clinical accreditation	☒ Give children living in most deprived communities the best start in life ☐ Outpatient blood pressure checks	☐ Zero tolerance to bullying

Implications / Impact	
Patient Safety	Safe staffing levels are fundamental to delivery of maternity services
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 1: Failure to provide care that consistently meets or exceeds performance and quality standards CRR 287 - Midwifery staffing
Financial	Midwifery establishment is set to BirthRate plus recommendations. The risk associated with maintaining safe staffing levels must be considered when developing cost improvement plans for the division. Allocating savings to the midwifery workforce cost centres in addition to trust wide cost avoidance plan associated with reduction in temporary staffing would enhance the clinical risk to maternity services and lead to further deterioration in staff wellbeing.
Compliance CQC Standards Safety	Safe Well Led Effective Responsive
Partnership: consultation / communication	NHSE/I, BOB LMNS
Equality	Safe staffing levels are integral to delivering personalised care, especially for women for whom experience poorer outcomes such as Black and Asian women and those from socially deprived areas.
Quality Impact Assessment [QIA] completion required?	No

Purpose

The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels from October 2023 to April 2024. This is a requirement of the NHS Resolution Maternity Incentive Scheme for safety action 5. The report also provides an accurate account of the current workforce status. In addition, gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this. A clear breakdown of BirthRate+ or equivalent calculations is included to demonstrate how the required establishment has been calculated.

Background

The Maternity Incentive Scheme requires that the maternity service demonstrates an effective system of midwifery workforce planning using the following standards prescribed within safety action 5 of the MIS.

The report provides assurance that:

- A systematic, evidence-based process to calculate midwifery staffing establishment been completed
- The Trust Board supports a midwifery staffing budget to reflect establishment as calculated in BirthRate+
- Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.
- The midwife to birth ratio is monitored
- The team of specialist midwives employed provides mitigation to cover any inconsistencies. (BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives)
- The midwifery coordinator in charge of labour ward maintains supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
- All women in active labour received one-to-one midwifery care
- A midwifery staffing oversight report is produced that covers staffing/safety issues to the Board at least every 6 months during the maternity incentive scheme year five reporting period.

The evidence described in this paper provides assurance the BHT has an effective system of midwifery workforce planning and monitoring of safe staffing levels, with the appropriate escalation plans in place.

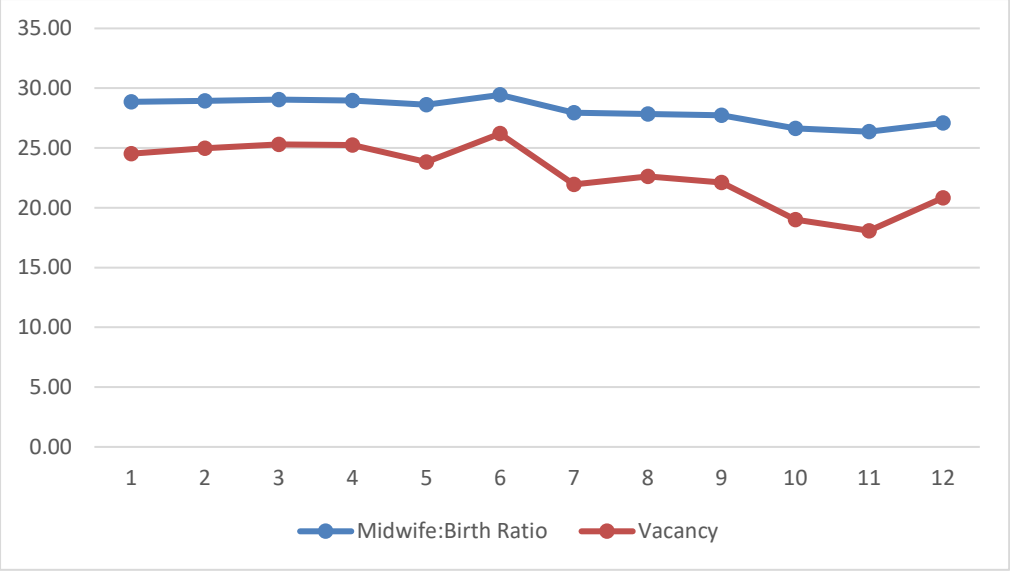
The activity within maternity services is dynamic and can change rapidly. It is therefore essential that there is adequate staffing in all areas to provide safe, high-quality care by staff who have the requisite skills and knowledge. Regular and ongoing monitoring of clinical activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation during times of high demand or low staffing numbers. BirthRate+ is a proven evidence-based methodology for calculating midwifery staffing requirements and is based on the case mix for women and babies accessing the service. This staffing report will include data from the 2022 BirthRate+ Report.

NICE (2015) publishes guidance on safer midwifery staffing and identifies red flags where further action is required to ensure safety of women and babies. This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags. These red flags are triangulated with the Trust's incident reporting system Datix and assurance is gained from there being no link to patient harm.

Current position

The below table presents the current workforce position for midwives, nurses, nursery nurses and maternity support workers (band 3 only) as at 31st March 2024.

	Establishment	**In post**	**Vacancy**	***Previous 6 months***
Midwives/nurses bands 5-8	191.31	151.46	20.83%	*27%*
Nursery Nurses	10.17	9.69	4.7%	*12.5%*
Maternity Support Workers (band 3 only)	13.29	12.76	3.9%	*13%*

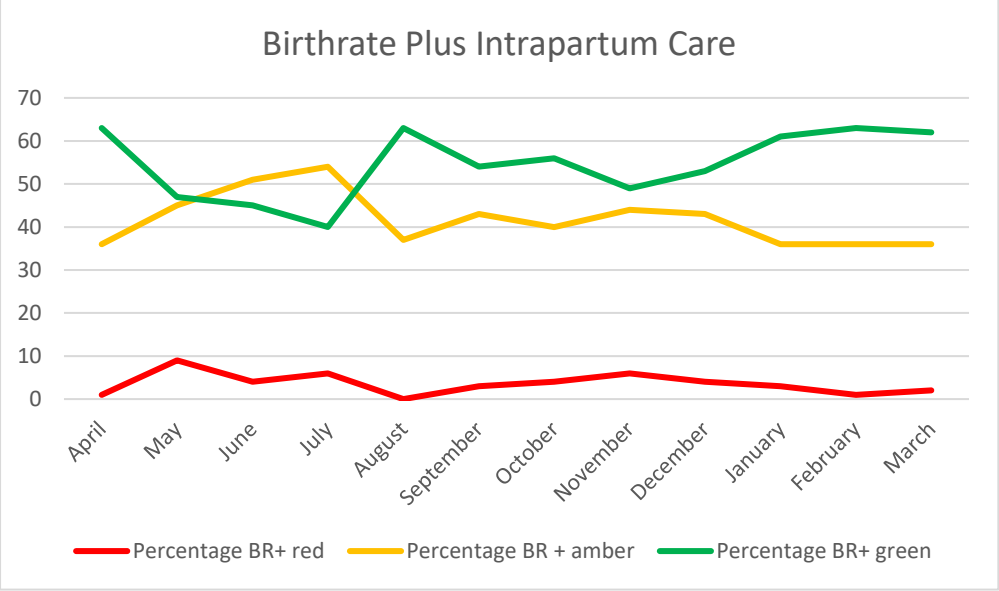


Unavailability

In addition to the current vacancy position, the speciality is also dealing with a significant amount of unavailability. Unavailability includes annual leave, study leave, sickness absence and maternity leave:

	October	November	December	January	February	March
Unavailability	52.35	55.88	43.22	54.48	61.10	50.05

Acuity



BirthRate+ analysis demonstrates episodes where the acuity is greater than establishment. BR+ red represents times where the labour ward was greater than two midwives short across the shift. BR+ amber represents times where the labour ward was up to two midwives short. BR+ green represents times where staffing levels were appropriate for acuity. The assessment of acuity versus staffing is undertaken 4-hourly on the labour ward. The table below demonstrates percentage recording deadlines met. BR+ is deemed reliable when recording of acuity 4 hourly is >90%. The table below demonstrates a significant

improvement in the percentage of reporting deadlines met from a baseline of 69% 12 months ago. The percentage of BR+ red events has been sustained at below 3% consistently, this is as a result of improved roster management which has led to greater smoothing across the roster.

	October	November	December	January	February	March
Percentage reporting deadlines met	89.9%	92.9%	94%	95.2%	88.1%	93.5%

Where acuity is greater than available qualified staff, a dynamic risk assessment is undertaken to redeploy staff from other clinical areas, specialist teams and management in order to maintain both supernumerary status of the labour ward coordinator and 1:1 care of women in labour.

NICE Red Flags

The service monitors NICE red flags via the morning safety huddle. The table below outlines the total number of red flags that are tracked by the service and the number of times the service is unable to maintain 1:1 care in labour or supernumerary status of the labour ward coordinator.

	Total no red flags	1:1 care in labour not maintained	Supernumerary status of LW coordinator not maintained	% BR+ red	%BR+ amber	%BR+ green
October 23	19	0	1	4	38	58
November 23	18	1	0	6	44	49
December 23	14	0	0	4	41	55
January 24	17	0	0	2	39	59
February 24	21	0	1	0	37	63
March 24	10	0	0	2	31	67

Across the six-month period there were two episodes where the labour ward coodinator was temporarily unable to maintain supernumerary status. These were brief periods during the shift when direct patient care was provided whilst staff were either deployed from other areas, or an on-call midwife or midwifery manager was enroute in order to maintain 1:1 care in labour.

Midwife: Birth Ratio

The table below presents the midwife to birth ratio which is determined by the number of births divided by the number of staff available each month. Based on BirthRate + analysis the midwife to birth ratio should be 24 births to 1 WTE midwife each month however the current figures are being impacted by the increase in unavailability and vacancy.

	October	November	December	January	February	March
Actual birth to WTE ratio	1:28	1:28	1:28	1:27	1:27	1:27

Mitigation

In order to support the workforce during this time of high unavailability and vacancy rates, the following measures have been introduced:

- All specialist midwives have been job planned to work clinically which supports their clinical credibility in addition to the day-to-day workforce. This operates as an ‘on demand’ service where clinical need is identified and is managed via an escalation rota to ensure equity across the team.
- The midwifery manager on call rota is maintained as a separate rota to the trust site on call scheme. This will not only provide oversight of the service but will provide further clinical support in times of escalation.
- Midwifery Continuity of Carer remains suspended in line with the immediate and essential actions of the final Ockenden report. Further rollout will not take place until the service can support safe staffing on all shifts, and there is evidence that this is a sustained position.
- 28 WTE newly qualified midwives are due to commence in post in October 2024 with a further 4 further experienced midwives joining from surrounding organisations in the next three months. This will result in a fall in vacancy rate to 4%. There is a risk that not all of the newly qualified midwives will not meet the requirements of the course and some will commit to multple organisations, which will impact upon this predicted drop in vacancy rate.
- Buckinghamshire New University have successfully received accreditation for the three-year direct entry midwifery apprenticeship. The Trust are supporting three maternity support workers to undertake this apprenticeship per year in order to provide a pipeline for the future.
- Ward managers all work clinically as part of their working week.
- Daily safety huddle across the Local Maternity and Neonatal System are well established to offer mutual aid across the system and reduce delays related to induction of labour. Reporting across the system is aligned to the OPEL framework.
- Additional support is being provided by the people directorate to not only improve the wellbeing of the current staff who are working under pressure, but to also provide recruitment support to provide a steadier pipeline of staff by raising the image of the service externally.
- Funding has been agreed with the ICB for a dedicated maternity recruitment and retention specialist for 12 months.

Conclusion

In response to the challenges of high workforce unavailability and vacancy rates, a series of strategic measures have been implemented to bolster support and stability within the midwifery service. These measures include the deployment of specialist midwives on an 'on-demand' basis, ensuring equitable distribution of clinical workload and maintaining clinical credibility. Furthermore, the establishment of a separate midwifery manager on-call roster and the suspension of Midwifery Continuity of Carer, in accordance with immediate priorities outlined in the final Ockenden report, aim to provide oversight, clinical support, and ensure safe staffing until sustained evidence supports further rollout.

Efforts to enhance workforce capacity include the planned onboarding of newly qualified midwives and experienced professionals, alongside initiatives such as supporting maternity support workers through apprenticeships. Combined with daily safety huddles, streamlined reporting aligned with the OPEL framework, and additional support from the people directorate and dedicated funding for a maternity recruitment and retention specialist, these measures demonstrate a concerted effort to address staffing challenges while fostering a sustainable and resilient midwifery workforce for the future.

Action required from the Board

The Board is requested to take assurance from the contents of this paper.

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

29 May 2024

Agenda item	Private Board Summary Report
Board Lead	Chief Executive Officer
Type name of Author	Senior Trust Board Administrator
Attachments	None
Purpose	Information
Previously considered	n/a

Executive Summary

The purpose of this report is to provide a summary of matters discussed at the Board meeting held in private on 24 April 2024.

The matters considered at this session of the Board were as follows:

- Trust Board Development Programme
- BHPL Annual Business Plan
- Water Hygiene Contract
- Operating Plan 2024/25
- Radiology Out of Hours Contract

Decision	The Board is requested to note the contents of the report.

Relevant Strategic Priority

Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☒

Relevant objective

☒ Improve waiting times in ED ☒ Improve elective waiting times ☒ Improve safety through clinical accreditation	☒ Give children living in most deprived communities the best start in life ☒ Outpatient blood pressure checks	☒ Zero tolerance to bullying

Implications / Impact

Patient Safety	Aspects of patient safety were considered at relevant points in the meeting
Risk: link to Board Assurance Framework (BAF)/Risk Register	Any relevant risk was highlighted within the reports and during the discussion
Financial	Where finance had an impact, it was highlighted and discussed as appropriate
Compliance	Compliance with legislation and CQC standards were highlighted when required or relevant
Partnership: consultation / communication	n/a
Equality	Any equality issues were highlighted and discussed as required.
Quality Impact Assessment [QIA] completion required?	No

Acronym 'Buster'

- A&E - Accident and Emergency
- AD - Associate Director
- ADT - Admission, Discharge and Transfer
- AfC - Agenda for Change
- AGM - Annual General Meeting
- AHP - Allied Health Professional
- AIS – Accessible Information Standard
- AKI - Acute Kidney Injury
- AMR - Antimicrobial Resistance
- ANP - Advanced Nurse Practitioner
- APC – Acute Provider Collaborative

B

- BBE - Bare Below Elbow
- BHT – Buckinghamshire Healthcare Trust
- BME - Black and Minority Ethnic
- BMA - British Medical Association
- BMI - Body Mass Index
- BOB – Buckinghamshire, Oxfordshire, Berkshire West
- BPPC – Better Payment Practice Code

C

- CAMHS - Child and Adolescent Mental Health Services
- CAS - Central Alert System
- CCG - Clinical Commissioning Group
- CCU - Coronary Care Unit
- Cdif / C.Diff - Clostridium Difficile
- CEA - Clinical Excellence Awards
- CEO - Chief Executive Officer
- CHD - Coronary Heart Disease
- CIO - Chief Information Officer
- CIP - Cost Improvement Plan
- CQC - Care Quality Commission
- CQUIN - Commissioning for Quality and Innovation
- CRL – Capital Resource Limit
- CSU - Commissioning Support Unit
- CT - Computerised Tomography
- CTG - Cardiotocography

D

- DBS - Disclosure Barring Service
- DGH - District General Hospital
- DH / DoH - Department of Health
- DIPC - Director of Infection Prevention and Control
- DNA - Did Not Attend
- DNACPR - Do Not Attempt Cardiopulmonary Resuscitation
- DNAR - Do Not Attempt Resuscitation
- DNR - Do Not Resuscitate
- DOH – Department of Health
- DoLS - Deprivation of Liberty Safeguards
- DPA - Data Protection Act
- DSU - Day Surgery Unit
- DVT - Deep Vein Thrombosis

E

- E&D - Equality and Diversity
- EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortization
- ECG - Electrocardiogram
- ED - Emergency Department
- EDD - Estimated Date of Discharge
- EIA - Equality Impact Assessment
- EIS – Elective Incentive Scheme
- ENT - Ear, Nose and Throat
- EOLC - End of Life Care
- EPR - Electronic Patient Record
- EPRR - Emergency Preparedness, Resilience and Response
- ESD - Early Supported Discharge
- ESR - Electronic Staff Record

F

- FBC - Full Business Case
- FFT - Friends and Family Test
- FOI - Freedom of Information
- FTE - Full Time Equivalent

G

- GI - Gastrointestinal
- GMC - General Medical Council
- GP - General Practitioner
- GRE – Glycopeptide Resistant Enterococci

H

- HAI - Hospital Acquired Infection
- HASU - Hyper Acute Stroke Unit
- HCA - Health Care Assistant
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HEE – Health Education England
- HETV - Health Education Thames Valley
- HMRC – Her Majesty's Revenue and Customs

- HSE - Health and Safety Executive
- HSLI – Health System Led Investment
- HSMR – Hospital-level Standardised Mortality Ratio
- HWB - Health and Wellbeing Board

I

- ICS – Integrated Care System
- ICB – Integrated Care Board

M

- I&E - Income and Expenditure
- IC - Information Commissioner
- ICP - Integrated Care Pathway
- ICU - Intensive Care Unit
- IG - Information Governance
- IGT / IGTK - Information Governance Toolkit
- IM&T - Information Management and Technology
- IPR - Individual Performance Review
- ITU - Intensive Therapy Unit / Critical Care Unit
- IV - Intravenous

J

- JAG - Joint Advisory Group

K

- KPI - Key Performance Indicator

L

- LA - Local Authority
- LCFS - Local Counter Fraud Specialist
- LD - Learning Disability
- LHRP - Local Health Resilience Partnership
- LiA - Listening into Action
- LOS / LoS - Length of Stay
- LUCADA - Lung Cancer Audit Data

M

- M&M - Morbidity and Mortality
- MDT - Multi-Disciplinary Team
- MIU - Minor Injuries Unit
- MRI - Magnetic Resonance Imaging
- MRSA - Meticillin-Resistant Staphylococcus Aureus

N

- NBOCAP - National Bowel Cancer Audit Programme
- NCASP - National Clinical Audit Support Programme

- NED - Non-Executive Director
- NHS – National Health Service
- NHSE – National Health Service England
- NHSE/I – National Health Service England & Improvement
- NHSI – Nation Health Service Improvement
- NHSLA - NHS Litigation Authority
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit
- NOGCA - National Oesophago-Gastric Cancer Audit
- NRLS - National Reporting and Learning System / Service

O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner
- OHD - Occupational Health Department
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy
- OUH - Oxford University Hospital

P

- PACS - Picture Archiving and Communications System / Primary and Acute Care System
- PALS - Patient Advice and Liaison Service
- PAS - Patient Administration System
- PBR - Payment by Results
- PBR Excluded – Items not covered under the PBR tariff
- PDC - Public Dividend Capital
- PDD - Predicted Date of Discharge
- PE - Pulmonary Embolism
- PFI - Private Finance Initiative
- PHE - Public Health England
- PICC - Peripherally Inserted Central Catheters
- PID - Patient / Person Identifiable Data
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMO - Programme Management Office
- PPE - Personal Protective Equipment
- PP – Private Patients
- PPI - Patient and Public Involvement
- PSED - Public Sector Equality Duty
- PSIRF – Patient Safety Incident Response Framework

Q

- QA - Quality Assurance
- QI - Quality Indicator
- QIP - Quality Improvement Plan
- QIPP - Quality, Innovation, Productivity and Prevention
- QIA - Quality Impact Assessment
- QOF - Quality and Outcomes Framework

R

- RAG - Red Amber Green
- RCA - Root Cause Analysis
- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RTT - Referral to Treatment

S

- SAU - Surgical Assessment Unit
- SCAS / SCAmb - South Central Ambulance Service
- SHMI - Summary Hospital-level Mortality Indicator
- SI - Serious Incident
- SIRI - Serious Incident Requiring Investigation
- SIRO – Senior Information Risk Owner
- SID - Senior Independent Director
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SMR - Standardised Mortality Ratio
- SoS - Secretary of State
- SSI(S) - Surgical Site Infections (Surveillance)
- SNAP - Sentinel Stroke National Audit Programme
- STF – Strategic Transformation Fund
- STP - Sustainability and Transformation Plan
- SUI - Serious Untoward Incident

T

- TIA - Transient Ischaemic Attack
- TNA - Training Needs Analysis
- TPN - Total Parenteral Nutrition
- TTA - To Take Away
- TTO - To Take Out
- TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981

U

- UGI - Upper Gastrointestinal
- UTI - Urinary Tract Infection

V

- VfM - Value for Money
- VSM - Very Senior Manager
- VTE - Venous Thromboembolism

W

- WHO - World Health Organization
- WTE - Whole Time Equivalent

Y

- YTD - Year to Date